



General Assembly

Substitute Bill No. 795

January Session, 2017

* SB00795PH 032917 *

**AN ACT ESTABLISHING THE OFFICE OF HEALTH STRATEGY AND
IMPROVING THE CERTIFICATE OF NEED PROGRAM.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective July 1, 2018*) (a) There is established an
2 Office of Health Strategy, which shall be within the Department of
3 Public Health for administrative purposes only. The department head
4 of said office shall be the executive director of the Office of Health
5 Strategy, who shall be appointed by the Governor in accordance with
6 the provisions of sections 4-5 to 4-8, inclusive, of the general statutes,
7 with the powers and duties therein prescribed.

8 (b) The Office of Health Strategy shall be responsible for the
9 following:

10 (1) Developing and implementing a comprehensive and cohesive
11 health care vision for the state, including, but not limited to, a
12 coordinated state health care cost containment strategy;

13 (2) Directing and overseeing (A) the all-payers claim database
14 program established pursuant to section 38-1091 of the general
15 statutes, and (B) the State Innovation Model Initiative and related
16 successor initiatives;

17 (3) Coordinating the state's health information technology

18 initiatives;

19 (4) Directing and overseeing the Office of Health Care Access and
20 all of its duties and responsibilities as set forth in chapter 368z of the
21 general statutes; and

22 (5) Convening forums and meetings with state government and
23 external stakeholders, including, but not limited to, the Connecticut
24 Health Insurance Exchange, to discuss health care issues designed to
25 develop effective health care cost and quality strategies.

26 (c) The Office of Health Strategy shall constitute a successor, in
27 accordance with the provisions of sections 4-38d, 4-38e and 4-39 of the
28 general statutes, to the functions, powers and duties of the following:

29 (1) The Connecticut Health Insurance Exchange, established
30 pursuant to section 38a-1081 of the general statutes, relating to the
31 administration of the all-payer claims database pursuant to section
32 38a-1091 of the general statutes; and

33 (2) The Office of the Lieutenant Governor, relating to the (A)
34 development of a chronic disease plan pursuant to section 19a-6q of
35 the general statutes, (B) housing, chairing and staffing of the Health
36 Care Cabinet pursuant to section 19a-725 of the general statutes, and
37 (C) (i) appointment of the health information technology officer
38 pursuant to section 19a-755 of the general statutes, and (ii) oversight of
39 the duties of such health information technology officer as set forth in
40 sections 17b-59, 17b-59a and 17b-59f of the general statutes, as
41 amended by this act.

42 (d) Any order or regulation of the entities listed in subdivisions (1)
43 and (2) of subsection (c) of this section that is in force on July 1, 2018,
44 shall continue in force and effect as an order or regulation until
45 amended, repealed or superseded pursuant to law.

46 Sec. 2. Section 19a-630 of the general statutes is repealed and the
47 following is substituted in lieu thereof (*Effective July 1, 2017*):

48 As used in this chapter, unless the context otherwise requires:

49 (1) "Access" means the availability of services to a population who
50 needs such services and the ability to obtain such services when
51 considering the location, reasonable available public or private
52 transportation options, hours of operation and language or cultural
53 considerations for the population seeking such services.

54 (2) "Affected community" means a municipality where a health care
55 facility is physically located or a municipality whose inhabitants are
56 regularly served by a health care facility.

57 [(1)] (3) "Affiliate" means a person, entity or organization
58 controlling, controlled by or under common control with another
59 person, entity or organization. Affiliate does not include a medical
60 foundation organized under chapter 594b.

61 [(2)] (4) "Applicant" means any person or health care facility that
62 applies for a certificate of need pursuant to section 19a-639a, as
63 amended by this act.

64 [(3)] "Bed capacity" means the total number of inpatient beds in a
65 facility licensed by the Department of Public Health under sections
66 19a-490 to 19a-503, inclusive.

67 (4) "Capital expenditure" means an expenditure that under
68 generally accepted accounting principles consistently applied is not
69 properly chargeable as an expense of operation or maintenance and
70 includes acquisition by purchase, transfer, lease or comparable
71 arrangement, or through donation, if the expenditure would have been
72 considered a capital expenditure had the acquisition been by
73 purchase.]

74 (5) "Behavioral health facility" means any facility that provides
75 mental health services to persons eighteen years of age or older or
76 substance use disorder services to persons of any age in an outpatient
77 treatment or residential setting to ameliorate mental, emotional,

78 behavioral or substance use disorder issues, including, but not limited
79 to, private freestanding mental health day treatment facilities.

80 [(5)] (6) "Certificate of need" means a certificate issued by the office.

81 [(6)] (7) "Days" means calendar days.

82 [(7)] (8) "Deputy commissioner" means the deputy commissioner of
83 Public Health who oversees the Office of Health Care Access division
84 of the Department of Public Health.

85 [(8)] (9) "Commissioner" means the Commissioner of Public Health.

86 [(9)] (10) "Free clinic" means a private, nonprofit community-based
87 organization that provides medical, dental, pharmaceutical or mental
88 health services at reduced cost or no cost to low-income, uninsured
89 and underinsured individuals.

90 (11) "Freestanding emergency department" means an emergency
91 department that is listed as a satellite location and held out to the
92 public by name, posted signs, advertising or other means as a place
93 that provides care for emergency medical conditions on an urgent
94 basis without requiring a previously scheduled appointment.

95 (12) "Health care services" means care and services of a medical,
96 mental health, substance use disorder treatment, surgical, psychiatric,
97 therapeutic, diagnostic or rehabilitative nature, including, but not
98 limited to, inpatient and outpatient acute hospital care and services.
99 For purposes of this subdivision, "inpatient" means a patient has been
100 formally admitted to a hospital on the order of a physician, and
101 "outpatient" means without a requirement that a patient be formally
102 admitted to a hospital to receive care.

103 (13) "Hospital" means a health care facility or institution licensed by
104 the Department of Public Health to provide both inpatient and
105 outpatient services as one of the following: (A) A general hospital
106 licensed by the Department of Public Health, including, but not limited

107 to, John Dempsey Hospital of The University of Connecticut Health
108 Center, as a short-term, acute care general or children's hospital; or (B)
109 a specialty hospital that provides chronic disease treatment, maternity,
110 inpatient psychiatric, rehabilitation or hospice services.

111 (14) "Hospital system" means: (A) A parent corporation of one or
112 more hospitals and any entity affiliated with such parent corporation
113 through ownership, governance or membership; or (B) a hospital and
114 any entity affiliated with such hospital through ownership,
115 governance or membership.

116 ~~[(10)]~~ (15) "Large group practice" means eight or more full-time
117 equivalent physicians, legally organized in a partnership, professional
118 corporation, limited liability company formed to render professional
119 services, medical foundation, not-for-profit corporation, faculty
120 practice plan or other similar entity (A) in which each physician who is
121 a member of the group provides substantially the full range of services
122 that the physician routinely provides, including, but not limited to,
123 medical care, consultation, diagnosis or treatment, through the joint
124 use of shared office space, facilities, equipment or personnel; (B) for
125 which substantially all of the services of the physicians who are
126 members of the group are provided through the group and are billed
127 in the name of the group practice and amounts so received are treated
128 as receipts of the group; or (C) in which the overhead expenses of, and
129 the income from, the group are distributed in accordance with
130 methods previously determined by members of the group. An entity
131 that otherwise meets the definition of group practice under this section
132 shall be considered a group practice although its shareholders,
133 partners or owners of the group practice include single-physician
134 professional corporations, limited liability companies formed to render
135 professional services or other entities in which beneficial owners are
136 individual physicians.

137 ~~[(11)]~~ (16) "Health care facility" means (A) hospitals; [licensed by the
138 Department of Public Health under chapter 368v; (B) specialty
139 hospitals; (C)] (B) freestanding emergency departments; ~~[(D)]~~ (C)

140 outpatient surgical facilities; [, as defined in section 19a-493b and
 141 licensed under chapter 368v; (E)] (D) a hospital or other facility or
 142 institution operated by the state that provides services that are eligible
 143 for reimbursement under Title XVIII or XIX of the federal Social
 144 Security Act, 42 USC 301, as amended; [(F) a central service facility; (G)
 145 mental health facilities; (H) substance abuse treatment facilities; and
 146 (I)] (E) behavioral health facilities; and (F) any other facility requiring
 147 certificate of need review pursuant to subsection (a) of section 19a-638,
 148 as amended by this act. "Health care facility" includes any parent
 149 company, subsidiary, affiliate or joint venture, or any combination
 150 thereof, of any such facility.

151 [(12) "Nonhospital based" means located at a site other than the
 152 main campus of the hospital.]

153 (17) "New hospital" means a hospital as it exists after the approval
 154 of an agreement pursuant to section 19a-486b, as amended by this act,
 155 or a certificate of need application for a transfer of ownership of a
 156 hospital;

157 [(13)] (18) "Office" means the Office of Health Care Access division
 158 within the Department of Public Health.

159 (19) "Outpatient surgical facility" has the same meaning as provided
 160 in section 19a-493b.

161 [(14)] (20) "Person" means any individual, partnership, corporation,
 162 limited liability company, association, governmental subdivision,
 163 agency or public or private organization of any character, but does not
 164 include the agency conducting the proceeding.

165 [(15)] (21) "Physician" has the same meaning as provided in section
 166 20-13a.

167 (22) "Purchaser" means (A) a person who is acquiring or has
 168 acquired any assets of a hospital through a transfer of ownership of a
 169 hospital; or (B) a hospital or hospital system that is acquiring or has

170 acquired any assets of a health care facility other than a hospital, or a
171 large group practice through a transfer of ownership.

172 (23) "Quality" means the degree to which health care services for
173 individuals or populations increase the likelihood of desired health
174 outcomes and are consistent with established professional knowledge,
175 standards and guidelines.

176 (24) "Relocation" means the movement of a health care facility from
177 its established location to a different location.

178 (25) "Reduction" means any modification to a health care service by
179 a hospital or hospital system that, independently or in conjunction
180 with other modifications or changes, results in a fifty per cent or
181 greater decrease in the availability of the health care service offered by
182 such hospital or hospital system or reduces the service area covered by
183 such hospital or hospital system.

184 (26) "Termination" means the elimination by a health care facility of
185 a health care service, but does not include a temporary suspension of
186 health care services lasting six months or less.

187 (27) "Transacting party" means a purchaser and any person who is a
188 party to a proposed agreement for (A) transfer of ownership of a
189 hospital; or (B) transfer of ownership of a health care facility or large
190 group practice to a hospital or hospital system.

191 (28) "Transfer" means to sell, lease, exchange, option, convey, give
192 or otherwise dispose of, including, but not limited to, transfer by way
193 of merger or joint venture not in the ordinary course of business.

194 [(16)] (29) "Transfer of ownership" means a transfer that impacts or
195 changes the governance or controlling body of a health care facility,
196 institution or large group practice, including, but not limited to, all
197 affiliations, mergers or any sale or transfer of net assets of a health care
198 facility.

199 Sec. 3. Section 19a-634 of the general statutes is repealed and the
200 following is substituted in lieu thereof (*Effective July 1, 2017*):

201 [(a) The Office of Health Care Access shall conduct, on a biennial
202 basis, a state-wide health care facility utilization study. Such study
203 may include an assessment of: (1) Current availability and utilization
204 of acute hospital care, hospital emergency care, specialty hospital care,
205 outpatient surgical care, primary care and clinic care; (2) geographic
206 areas and subpopulations that may be underserved or have reduced
207 access to specific types of health care services; and (3) other factors that
208 the office deems pertinent to health care facility utilization. Not later
209 than June thirtieth of the year in which the biennial study is conducted,
210 the Commissioner of Public Health shall report, in accordance with
211 section 11-4a, to the Governor and the joint standing committees of the
212 General Assembly having cognizance of matters relating to public
213 health and human services on the findings of the study. Such report
214 may also include the office's recommendations for addressing
215 identified gaps in the provision of health care services and
216 recommendations concerning a lack of access to health care services.

217 (b) The office,] (a) The Office of Health Care Access, in consultation
218 with such other state agencies as the Commissioner of Public Health
219 deems appropriate, shall establish and maintain a state-wide health
220 care facilities and services plan. Such plan [may] shall, within available
221 appropriations, include, but not be limited to: (1) [An] A state-wide
222 health care facility utilization study, consisting of an assessment of the
223 availability and utilization of acute hospital care, hospital emergency
224 care, specialty hospital care, outpatient surgical care, primary care and
225 clinic care; (2) an evaluation of the unmet needs of persons at risk and
226 vulnerable populations as determined by the commissioner; (3) the
227 identification of geographic areas that may be underserved or have
228 reduced access to specific types of health care services; (4) a projection
229 of future demand for health care services and the impact that
230 technology may have on the demand, capacity or need for such
231 services; (5) the identification of clinical best practices, as applicable to

232 certificate of need requirements under section 19a-638, as amended by
 233 this act; and [(4)] (6) recommendations for [the expansion, reduction or
 234 modification of health care facilities or services] (A) addressing
 235 identified unmet health care needs, (B) integrating and aligning clinical
 236 best practices into licensure requirements or other ongoing monitoring
 237 efforts by the department to enhance quality of care, and (C) any
 238 improvements or changes necessary to the office's programs, including
 239 the certificate of need process, in order to promote health equity. In the
 240 development of the plan, the office shall consider the
 241 recommendations of any advisory bodies which may be established by
 242 the commissioner. The commissioner may also incorporate the
 243 recommendations of authoritative organizations whose mission is to
 244 promote policies based on best practices or evidence-based research.
 245 The commissioner, in consultation with hospital, hospital system and
 246 other health care facility representatives, shall develop a process that
 247 encourages [hospitals] such entities to incorporate the state-wide
 248 health care facilities and services plan into [hospital] long-range
 249 planning and shall facilitate communication between appropriate state
 250 agencies concerning innovations or changes that may affect future
 251 health planning. The office shall update the state-wide health care
 252 facilities and services plan not less than once every two years.

253 [(c)] (b) For purposes of [conducting the state-wide health care
 254 facility utilization study and] preparing the state-wide health care
 255 facilities and services plan, the office shall establish and maintain an
 256 inventory of all health care facilities, the equipment identified in
 257 [subdivisions (9) and (10)] subdivision (7) of subsection (a) of section
 258 19a-638, as amended by this act, and services in the state, including
 259 health care facilities that are exempt from certificate of need
 260 requirements under subsection (b) of section 19a-638, as amended by
 261 this act. The office [shall develop] may utilize an inventory
 262 questionnaire to obtain the following information: (1) The name and
 263 location of the facility; (2) the type of facility; (3) the hours of operation;
 264 (4) the type of services provided at that location; and (5) the total
 265 number of clients, treatments, patient visits, procedures performed or

266 scans performed in a calendar year. The inventory shall be completed
267 [biennially] every three years by health care facilities and providers
268 and such health care facilities and providers shall not be required to
269 provide patient specific or financial data.

270 Sec. 4. Section 19a-637 of the general statutes is repealed and the
271 following is substituted in lieu thereof (*Effective July 1, 2017*):

272 The office shall promote effective health planning in the state. In
273 carrying out its assigned duties, the office shall promote the provision
274 of quality health care in a manner that ensures access for all state
275 residents to cost-effective services so as to [avoid duplication of health
276 services and] improve the availability and financial stability of health
277 care services throughout the state.

278 Sec. 5. Section 19a-638 of the general statutes is repealed and the
279 following is substituted in lieu thereof (*Effective July 1, 2017*):

280 (a) A certificate of need issued by the office shall be required for:

281 (1) The establishment of a new [health care facility] hospital,
282 freestanding emergency department or outpatient surgical facility,
283 except as provided in section 19a-639e, as amended by this act;

284 (2) A transfer of ownership of a health care facility;

285 (3) A transfer of ownership of a hospital to another hospital,
286 hospital system or other entity;

287 [(3)] (4) A transfer of ownership of a large group practice to any
288 entity other than a (A) physician, or (B) group of two or more
289 physicians, legally organized in a partnership, professional
290 corporation or limited liability company formed to render professional
291 services and not employed by or an affiliate of any hospital, medical
292 foundation, insurance company or other similar entity;

293 [(4) The establishment of a freestanding emergency department;]

294 (5) The termination of an emergency department or inpatient or
295 outpatient services offered by a hospital, [including, but not limited to,
296 the termination by a short-term acute care general hospital or
297 children's hospital of inpatient and outpatient mental health and
298 substance abuse services] hospital system or other facility or institution
299 operated by the state that provides services that are eligible for
300 reimbursement under Title XVIII or XIX of the federal Social Security
301 Act, 42 USC 301, as amended from time to time, except (A) the
302 termination of services due to insufficient patient volume or lack of
303 available practitioners to support the effective delivery of care that is
304 subject to the termination request process set forth in section 19a-639e,
305 as amended by this act, and (B) the termination of services for which
306 the Department of Public health has requested the hospital to
307 relinquish its license;

308 [(6) The establishment of an outpatient surgical facility, as defined
309 in section 19a-493b, or as established by a short-term acute care general
310 hospital;

311 (7) The termination of surgical services by an outpatient surgical
312 facility, as defined in section 19a-493b, or a facility that provides
313 outpatient surgical services as part of the outpatient surgery
314 department of a short-term acute care general hospital, provided
315 termination of outpatient surgical services due to (A) insufficient
316 patient volume, or (B) the termination of any subspecialty surgical
317 service, shall not require certificate of need approval;

318 (8) The termination of an emergency department by a short-term
319 acute care general hospital;]

320 [(9)] (6) The establishment of cardiac services, including inpatient
321 and outpatient cardiac catheterization, interventional cardiology and
322 cardiovascular surgery; and

323 [(10)] (7) The acquisition of scanners that utilize imaging techniques,
324 including, but not limited to, computed tomography, [scanners,]

325 magnetic resonance imaging, [scanners,] positron emission
326 tomography, [scanners or] positron emission tomography-computed
327 tomography [scanners,] or single-photon emission computed
328 tomography by any person, physician, provider [, short-term acute
329 care general hospital or children's hospital, except (A) as provided for
330 in subdivision (22) of subsection (b) of this section, and (B) a certificate
331 of need issued by the office shall not be required where such scanner is
332 a replacement for a scanner that was previously acquired through
333 certificate of need approval or a certificate of need determination;] or
334 hospital that filed a request pursuant to subsection (b) of section 19a-
335 639e, as amended by this act, and did not sufficiently demonstrate to
336 the satisfaction of the office that methods will be employed to
337 minimize the practice of patient referrals in which the referring
338 provider stands to financially gain from such referral and that
339 Medicaid recipients and indigent persons will have access to services
340 provided utilizing the acquired equipment.

341 [(11) The acquisition of nonhospital based linear accelerators;

342 (12) An increase in the licensed bed capacity of a health care facility;

343 (13) The acquisition of equipment utilizing technology that has not
344 previously been utilized in the state;

345 (14) An increase of two or more operating rooms within any three-
346 year period, commencing on and after October 1, 2010, by an
347 outpatient surgical facility, as defined in section 19a-493b, or by a
348 short-term acute care general hospital; and

349 (15) The termination of inpatient or outpatient services offered by a
350 hospital or other facility or institution operated by the state that
351 provides services that are eligible for reimbursement under Title XVIII
352 or XIX of the federal Social Security Act, 42 USC 301, as amended.]

353 (b) A certificate of need shall not be required for:

354 (1) Health care facilities owned and operated by the federal

355 government;

356 (2) The establishment of offices by a licensed private practitioner,
357 whether for individual or group practice, except when a certificate of
358 need is required in accordance with the requirements of section 19a-
359 493b or subdivision [(3), (10) or (11)] (4) or (7) of subsection (a) of this
360 section;

361 (3) A health care facility operated by a religious group that
362 exclusively relies upon spiritual means through prayer for healing;

363 (4) Residential care homes, nursing homes and rest homes, as
364 defined in subsection (c) of section 19a-490;

365 (5) An assisted living services agency, as defined in section 19a-490;

366 (6) Home health agencies, as defined in section 19a-490;

367 (7) Hospice services, as described in section 19a-122b;

368 (8) Outpatient rehabilitation facilities;

369 (9) Outpatient chronic dialysis services;

370 (10) Transplant services;

371 (11) Free clinics, as defined in section 19a-630, as amended by this
372 act;

373 (12) School-based health centers and expanded school health sites,
374 as such terms are defined in section 19a-6r, community health centers,
375 as defined in section 19a-490a, not-for-profit outpatient clinics licensed
376 in accordance with the provisions of chapter 368v and federally
377 qualified health centers;

378 (13) A program licensed or funded by the Department of Children
379 and Families, provided such program is not a psychiatric residential
380 treatment facility;

381 (14) Any nonprofit facility, institution or provider that has a contract
382 with, or is certified or licensed to provide a service for, a state agency
383 or department for a service that would otherwise require a certificate
384 of need. The provisions of this subdivision shall not apply to a short-
385 term acute care general hospital or children's hospital, or a hospital or
386 other facility or institution operated by the state that provides services
387 that are eligible for reimbursement under Title XVIII or XIX of the
388 federal Social Security Act, 42 USC 301, as amended;

389 (15) A health care facility operated by a nonprofit educational
390 institution exclusively for students, faculty and staff of such institution
391 and their dependents;

392 (16) An outpatient clinic or program operated exclusively by or
393 contracted to be operated exclusively by a municipality, municipal
394 agency, municipal board of education or a health district, as described
395 in section 19a-241;

396 (17) A residential facility for persons with intellectual disability
397 licensed pursuant to section 17a-227 and certified to participate in the
398 Title XIX Medicaid program as an intermediate care facility for
399 individuals with intellectual disabilities;

400 (18) Replacement of existing imaging equipment with similar
401 imaging equipment if such equipment was acquired through certificate
402 of need approval or a certificate of need determination, provided a
403 health care facility, provider, physician or person notifies the office of
404 the date on which the equipment is replaced and the disposition of the
405 replaced equipment;

406 (19) Acquisition of cone-beam dental imaging equipment that is to
407 be used exclusively by a dentist licensed pursuant to chapter 379; or

408 [(20) The partial or total elimination of services provided by an
409 outpatient surgical facility, as defined in section 19a-493b, except as
410 provided in subdivision (6) of subsection (a) of this section and section
411 19a-639e;

412 (21) The termination of services for which the Department of Public
413 Health has requested the facility to relinquish its license; or]

414 [(22)] (20) Acquisition of any equipment by any person that is to be
415 used exclusively for scientific research that is not conducted on
416 humans.

417 (c) [(1)] Any person, health care facility or institution that is unsure
418 whether a certificate of need is required under this section [, or (2) any
419 health care facility that proposes to relocate pursuant to section 19a-
420 639c] shall send a letter to the office that describes the project and
421 requests that the office make a determination as to whether a certificate
422 of need is required. [In the case of a relocation of a health care facility,
423 the letter shall include information described in section 19a-639c.] A
424 person, health care facility or institution making such request shall
425 provide the office with any information the office requests as part of its
426 determination process.

427 (d) The Commissioner of Public Health may implement policies and
428 procedures necessary to administer the provisions of this section while
429 in the process of adopting such policies and procedures as regulation,
430 provided the commissioner holds a public hearing prior to
431 implementing the policies and procedures and prints notice of intent to
432 adopt regulations in the Connecticut Law Journal not later than twenty
433 days after the date of implementation. Policies and procedures
434 implemented pursuant to this section shall be valid until the time final
435 regulations are adopted. [Final regulations shall be adopted by
436 December 31, 2011.]

437 Sec. 6. Section 19a-639 of the general statutes is repealed and the
438 following is substituted in lieu thereof (*Effective July 1, 2017*):

439 (a) In any deliberations involving a certificate of need application
440 filed pursuant to subdivisions (1), (2), (4), (6) and (7) of subsection (a)
441 of section 19a-638, as amended by this act, the office shall take into
442 consideration and make written findings concerning each of the

443 following guidelines and principles, as applicable:

444 (1) Whether the [proposed project] proposal is consistent with any
445 applicable policies and standards adopted in regulations by the
446 Department of Public Health;

447 (2) [The relationship of the proposed project to] Whether the
448 proposal is aligned with the state-wide health care facilities and
449 services plan established under section 19a-634, as amended by this
450 act, including whether the proposal will serve individuals in
451 geographic areas that are underserved or have reduced access to
452 specific types of health care services;

453 [(3) Whether there is a clear public need for the health care facility
454 or services proposed by the applicant;

455 (4) Whether the applicant has satisfactorily demonstrated how the
456 proposal will impact the financial strength of the health care system in
457 the state or that the proposal is financially feasible for the applicant;]

458 [(5)] (3) Whether the applicant has satisfactorily demonstrated
459 [how] that the proposal will not adversely impact the health care
460 market in the state, will improve quality, accessibility and cost
461 effectiveness of health care delivery in the region [, including, but not
462 limited to, provision of or any change in the access to services for
463 Medicaid recipients and indigent persons] and, as applicable to the
464 acquisition of scanners, will minimize the practice of patient referrals
465 in which the referring practitioner will stand to financially gain from
466 such referral;

467 [(6)] (4) The applicant's past and proposed provision of health care
468 services to relevant patient populations and payer mix, including [, but
469 not limited to,] whether the applicant has satisfactorily demonstrated
470 how the proposal will provide access to services by Medicaid
471 recipients and indigent persons; and

472 [(7) Whether the applicant has satisfactorily identified the

473 population to be served by the proposed project and satisfactorily
474 demonstrated that the identified population has a need for the
475 proposed services;

476 (8) The utilization of existing health care facilities and health care
477 services in the service area of the applicant;

478 (9) Whether the applicant has satisfactorily demonstrated that the
479 proposed project shall not result in an unnecessary duplication of
480 existing or approved health care services or facilities;

481 (10) Whether an applicant, who has failed to provide or reduced
482 access to services by Medicaid recipients or indigent persons, has
483 demonstrated good cause for doing so, which shall not be
484 demonstrated solely on the basis of differences in reimbursement rates
485 between Medicaid and other health care payers;]

486 [(11)] (5) Whether the applicant has satisfactorily demonstrated that
487 the proposal will not negatively impact the [diversity of health care
488 providers and] patient choice of providers in the geographic region. [;
489 and]

490 [(12) Whether the applicant has satisfactorily demonstrated that any
491 consolidation resulting from the proposal will not adversely affect
492 health care costs or accessibility to care.

493 (b) In deliberations as described in subsection (a) of this section,
494 there shall be a presumption in favor of approving the certificate of
495 need application for a transfer of ownership of a large group practice,
496 as described in subdivision (3) of subsection (a) of section 19a-638,
497 when an offer was made in response to a request for proposal or
498 similar voluntary offer for sale.

499 (c) The office, as it deems necessary, may revise or supplement the
500 guidelines and principles through regulation prescribed in subsection
501 (a) of this section.

502 (d) (1) For purposes of this subsection and subsection (e) of this
503 section:

504 (A) "Affected community" means a municipality where a hospital is
505 physically located or a municipality whose inhabitants are regularly
506 served by a hospital;

507 (B) "Hospital" has the same meaning as provided in section 19a-490;

508 (C) "New hospital" means a hospital as it exists after the approval of
509 an agreement pursuant to section 19a-486b or a certificate of need
510 application for a transfer of ownership of a hospital;

511 (D) "Purchaser" means a person who is acquiring, or has acquired,
512 any assets of a hospital through a transfer of ownership of a hospital;

513 (E) "Transacting party" means a purchaser and any person who is a
514 party to a proposed agreement for transfer of ownership of a hospital;

515 (F) "Transfer" means to sell, transfer, lease, exchange, option,
516 convey, give or otherwise dispose of or transfer control over,
517 including, but not limited to, transfer by way of merger or joint
518 venture not in the ordinary course of business; and

519 (G) "Transfer of ownership of a hospital" means a transfer that
520 impacts or changes the governance or controlling body of a hospital,
521 including, but not limited to, all affiliations, mergers or any sale or
522 transfer of net assets of a hospital and for which a certificate of need
523 application or a certificate of need determination letter is filed on or
524 after December 1, 2015.]

525 (b) In any deliberations involving a certificate of need application
526 filed pursuant to subdivision (5) of subsection (a) of section 19a-638, as
527 amended by this act, the office shall take into consideration and make
528 written findings concerning each of the following guidelines and
529 principles, as applicable:

530 (1) Whether the proposal is consistent with any applicable policies
531 and standards adopted in regulations by the Department of Public
532 Health;

533 (2) Whether the proposal is aligned with the state-wide health care
534 facilities and services plan established under section 19a-634, as
535 amended by this act, including whether the proposal will affect
536 individuals in geographic areas that are underserved or have reduced
537 access to specific types of health care services;

538 (3) Whether the applicant has satisfactorily demonstrated that the
539 proposal will not adversely impact quality, accessibility and cost
540 effectiveness of health care delivery in the region;

541 (4) The applicant's past provision of health care services to relevant
542 patient populations and payer mix, including whether the applicant
543 has satisfactorily demonstrated how the proposal will not adversely
544 impact access to services by Medicaid recipients and indigent persons;

545 (5) Whether the applicant has satisfactorily identified the population
546 that currently utilizes a service proposed for termination, reduction or
547 relocation and satisfactorily demonstrated that the identified
548 population has access to alternative locations in which such population
549 may be able to obtain the services proposed for termination, reduction
550 or relocation;

551 (6) The utilization of existing health care facilities and health care
552 services in the service area of the applicant;

553 (7) Whether the applicant has demonstrated good cause for a
554 proposed termination, reduction or relocation that (A) will result in
555 reduced access to services by Medicaid recipients or indigent persons,
556 or (B) is located in a geographic area that is underserved or has
557 reduced access to specific types of services, provided good cause shall
558 not be demonstrated solely on the basis of differences in
559 reimbursement rates between Medicaid and other health care payers;
560 and

561 (8) Whether the applicant has satisfactorily demonstrated that the
562 proposal will not negatively impact the patient choice of provider in
563 the geographic region.

564 [(2)] (c) In any deliberations involving a certificate of need
565 application filed pursuant to subdivision (3) of subsection (a) of section
566 19a-638, [that involves the transfer of ownership of a hospital, the
567 office shall, in addition to the guidelines and principles set forth in
568 subsection (a) of this section and those prescribed through regulation
569 pursuant to subsection (c) of this section,] as amended by this act, the
570 office shall take into consideration and make written findings
571 concerning each of the following guidelines and principles, as
572 applicable:

573 [(A)] (1) Whether the applicant fairly considered alternative
574 proposals or offers in light of the purpose of maintaining health care
575 provider diversity and consumer choice in the health care market and
576 access to affordable quality health care for the affected community;
577 [and]

578 [(B)] (2) Whether the plan submitted pursuant to section 19a-639a,
579 as amended by this act, demonstrates, in a manner consistent with this
580 chapter, how health care services will be provided by the new hospital
581 for the first three years following the transfer of ownership of the
582 hospital, including any consolidation, reduction, elimination or
583 expansion of existing services or introduction of new services; [.]

584 (3) Whether the proposed project is aligned with the state-wide
585 health care facilities and services plan established under section 19a-
586 634, as amended by this act, including whether the proposed project
587 will serve individuals in geographic areas that are underserved or
588 have reduced access to specific types of health care services;

589 (4) Whether the applicant has satisfactorily demonstrated that the
590 proposal will improve quality, accessibility and cost effectiveness of
591 health care delivery in the region and that any consolidation resulting

592 from the proposal will not adversely affect health care costs or
593 accessibility to care;

594 (5) The applicant's past and proposed provision of health care
595 services to relevant patient populations and payer mix, including
596 whether the applicant has satisfactorily demonstrated how the
597 proposal will provide access to services by Medicaid recipients and
598 indigent persons; and

599 (6) Whether the applicant has satisfactorily demonstrated that the
600 proposal will not negatively impact patient choice of provider in the
601 geographic region.

602 [(3)] (d) The office shall deny any certificate of need application
603 involving a transfer of ownership of a hospital unless the
604 commissioner finds that the affected community will be assured of
605 continued access to high quality and affordable health care after
606 accounting for any proposed change impacting hospital staffing.

607 [(4)] (e) The office may deny any certificate of need application
608 involving a transfer of ownership of a hospital subject to a cost and
609 market impact review pursuant to section 19a-639f, as amended by this
610 act, if the commissioner finds that [(A)] (1) the affected community will
611 not be assured of continued access to high quality and affordable
612 health care after accounting for any consolidation in the hospital and
613 health care market that may lessen health care provider diversity,
614 consumer choice and access to care, and [(B)] (2) any likely increases in
615 the prices for health care services or total health care spending in the
616 state may negatively impact the affordability of care.

617 [(5) The office may place any conditions on the approval of a
618 certificate of need application involving a transfer of ownership of a
619 hospital consistent with the provisions of this chapter. Before placing
620 any such conditions, the office shall weigh the value of such conditions
621 in promoting the purposes of this chapter against the individual and
622 cumulative burden of such conditions on the transacting parties and

623 the new hospital. For each condition imposed, the office shall include a
624 concise statement of the legal and factual basis for such condition and
625 the provision or provisions of this chapter that it is intended to
626 promote. Each condition shall be reasonably tailored in time and
627 scope. The transacting parties or the new hospital shall have the right
628 to make a request to the office for an amendment to, or relief from, any
629 condition based on changed circumstances, hardship or for other good
630 cause.]

631 (f) In deliberations, as described in subsection (a) of this section,
632 there shall be a presumption in favor of approving the certificate of
633 need application for a transfer of ownership of a large group practice,
634 as described in subdivision (4) of subsection (a) of section 19a-638, as
635 amended by this act, when an offer was made in response to a request
636 for proposal or similar voluntary offer for sale.

637 ~~[(e)]~~ (g) (1) If the certificate of need application (A) involves the
638 transfer of ownership of a hospital, (B) the purchaser is a hospital, as
639 defined in section 19a-490, whether located within or outside the state,
640 that had net patient revenue for fiscal year 2013 in an amount greater
641 than one billion five hundred million dollars or a hospital system, as
642 defined in section 19a-486i, whether located within or outside the state,
643 that had net patient revenue for fiscal year 2013 in an amount greater
644 than one billion five hundred million dollars, or any person that is
645 organized or operated for profit, and (C) such application is approved,
646 the office shall hire an independent consultant, who shall have no
647 previous financial interest with the hospital or hospital system, or any
648 affiliate of the hospital or hospital system, no previous sanctions and
649 no adverse decisions regarding monitoring activities, to serve as a
650 post-transfer compliance reporter for a period of three years after
651 completion of the transfer of ownership of the hospital. Such reporter
652 shall, at a minimum: (i) Meet with representatives of the purchaser, the
653 new hospital and members of the affected community served by the
654 new hospital not less than quarterly; and (ii) report to the office not
655 less than quarterly concerning (I) efforts the purchaser and

656 representatives of the new hospital have taken to comply with any
657 conditions the office placed on the approval of the certificate of need
658 application and plans for future compliance, and (II) community
659 benefits and uncompensated care provided by the new hospital. The
660 purchaser shall give the reporter access to its records and facilities for
661 the purposes of carrying out the reporter's duties. The purchaser shall
662 hold a public hearing in the municipality in which the new hospital is
663 located not less than annually during the reporting period to provide
664 for public review and comment on the reporter's reports and findings.

665 (2) If the reporter finds that the purchaser has breached a condition
666 of the approval of the certificate of need application, the office may [,
667 in] take one or more of the following actions: (A) In consultation with
668 the purchaser, the reporter and any other interested parties it deems
669 appropriate, implement a performance improvement plan designed to
670 remedy the conditions identified by the reporter and continue the
671 reporting period for up to one year following a determination by the
672 office that such conditions have been resolved; (B) institute an action to
673 enjoin the purchaser from engaging in conduct in violation of the
674 certificate of need; or (C) impose a civil penalty in accordance with
675 section 19a-653, as amended by this act. For the breach of conditions
676 specifying cost or price limits, the office may require partial or full
677 refunding or repayment of the amount in excess of the conditioned
678 limits to the affected payer, as applicable.

679 (3) [The purchaser shall provide funds, in an amount determined by
680 the office not to exceed two hundred thousand dollars annually, for
681 the hiring of the post-transfer compliance reporter.] Upon the filing of
682 an application involving the transfer of ownership, the purchaser shall
683 establish an escrow account pursuant to a formal escrow agreement
684 provided by the office for the purpose of paying the bills for services
685 provided by the independent consultant. The purchaser shall initially
686 fund the escrow account with two hundred thousand dollars. The
687 escrow agent shall pay such bills out of the escrow account directly to
688 the independent consultant not later than thirty days after receipt of

689 each bill by the purchaser.

690 [(f) Nothing in subsection (d) or (e) of this section shall apply to a
691 transfer of ownership of a hospital in which either a certificate of need
692 application is filed on or before December 1, 2015, or where a
693 certificate of need determination letter is filed on or before December 1,
694 2015.]

695 (h) The office may place any conditions on the approval of any
696 certificate of need application consistent with the provisions of this
697 chapter. Before placing any such conditions, the office shall weigh the
698 value of such conditions in promoting the purposes of this chapter
699 against the individual and cumulative burden of such conditions on
700 the applicant or any transacting parties. For each condition imposed,
701 the office shall include a concise statement of the legal and factual
702 basis for such condition and the provision or provisions of this chapter
703 that it is intended to promote. Any condition imposed by the office
704 shall be reasonably tailored in time and scope. The applicant or any
705 applicable transacting parties shall have the right to make a request to
706 the office for an amendment to, or relief from, any condition based on
707 changed circumstances, hardship or for other good cause.

708 (i) The Commissioner of Public Health may adopt regulations, in
709 accordance with the provisions of chapter 54 to carry out the
710 provisions of this section.

711 Sec. 7. Section 19a-639a of the general statutes is repealed and the
712 following is substituted in lieu thereof (*Effective July 1, 2017*):

713 (a) An application for a certificate of need shall be filed with the
714 office in accordance with the provisions of this section and any
715 regulations adopted by the Department of Public Health. The
716 application shall address the guidelines and principles set forth in (1)
717 subsection (a) of section 19a-639, as amended by this act, and (2)
718 regulations adopted by the department. The applicant shall include
719 with the application a nonrefundable application fee of five hundred

720 dollars.

721 (b) [Prior] Not later than twenty days prior to the filing of a
722 certificate of need application, the applicant shall (1) publish notice for
723 not less than three consecutive days that an application is to be
724 submitted to the office in a newspaper having a substantial circulation
725 in the area where the project is to be located, and (2) request the
726 publication of notice in at least two sites within the affected
727 community that are commonly accessed by the public, such as a town
728 hall or library, and on any existing Internet web site of the
729 municipality or local health department. Such notice shall [(1) be
730 published (A) not later than twenty days prior to the date of filing of
731 the certificate of need application, and (B) for not less than three
732 consecutive days, and (2)] contain a brief description of the nature of
733 the project and the street address where the project is to be located. An
734 applicant shall file the certificate of need application with the office not
735 later than ninety days after publishing notice of the application in
736 accordance with the provisions of this subsection. The office shall not
737 accept the applicant's certificate of need application for filing unless
738 the application is accompanied by the application fee prescribed in
739 subsection (a) of this section and proof of compliance with the
740 publication requirements prescribed in this subsection.

741 (c) (1) Not later than five business days after receipt of a properly
742 filed certificate of need application, the office shall publish notice of the
743 application on its Internet web site. Not later than thirty days after the
744 date of filing of the application, the office may request such additional
745 information as the office determines necessary to complete the
746 application. In addition to any information requested by the office, if
747 the application involves the transfer of ownership of a hospital, as
748 defined in section [19a-639] 19a-630, as amended by this act, the
749 applicant shall submit to the office (A) a plan demonstrating how
750 health care services will be provided by the new hospital for the first
751 three years following the transfer of ownership of the hospital,
752 including any consolidation, reduction, elimination or expansion of

753 existing services or introduction of new services, and (B) the names of
754 persons currently holding a position with the hospital to be purchased
755 or the purchaser, as defined in section [19a-639] 19a-630, as amended
756 by this act, as an officer, director, board member or senior manager,
757 whether or not such person is expected to hold a position with the
758 hospital after completion of the transfer of ownership [of the hospital]
759 and any salary, severance, stock offering or any financial gain, current
760 or deferred, such person is expected to receive as a result of, or in
761 relation to, the transfer of ownership of the hospital.

762 (2) The applicant shall, not later than sixty days after the date of the
763 office's request, submit any requested information and any
764 information required under this subsection to the office. If an applicant
765 fails to submit such information to the office within the sixty-day
766 period, the office shall consider the application to have been
767 withdrawn.

768 (d) Upon determining that an application is complete, the office
769 shall provide notice of this determination to the applicant and to the
770 public in accordance with regulations adopted by the department. In
771 addition, the office shall post such notice on its Internet web site and
772 provide the link to the completed application to any entity that
773 published notice in accordance with subsection (b) of this section for
774 publication of such completed application. The date on which the
775 office posts such notice on its Internet web site shall begin the review
776 period. Except as provided in this subsection, (1) the review period for
777 a completed application shall be ninety days from the date on which
778 the office posts such notice on its Internet web site; and (2) the office
779 shall issue a decision on a completed application prior to the
780 expiration of the ninety-day review period. The review period for a
781 completed application that involves a transfer of a large group
782 practice, as described in subdivision [(3)] (4) of subsection (a) of section
783 19a-638, as amended by this act, when the offer was made in response
784 to a request for proposal or similar voluntary offer for sale, shall be
785 sixty days from the date on which the office posts notice on its Internet

786 web site. Upon request or for good cause shown, the office may extend
787 the review period for a period of time not to exceed sixty days. If the
788 review period is extended, the office shall issue a decision on the
789 completed application prior to the expiration of the extended review
790 period. If the office holds a public hearing concerning a completed
791 application in accordance with subsection (e) or (f) of this section, the
792 office shall issue a decision on the completed application not later than
793 sixty days after the date the office closes the public hearing record.

794 (e) [Except as provided in this subsection, the] The office shall hold
795 a public hearing on a properly filed and completed certificate of need
796 application if three or more individuals or an individual representing
797 an entity with five or more people submits a request, in writing, that a
798 public hearing be held on the application. For a properly filed and
799 completed certificate of need application involving a transfer of
800 ownership of a large group practice, as described in subdivision [(3)]
801 (4) of subsection (a) of section 19a-638, as amended by this act, when
802 an offer was made in response to a request for proposal or similar
803 voluntary offer for sale, a public hearing shall be held if twenty-five or
804 more individuals or an individual representing twenty-five or more
805 people submits a request, in writing, that a public hearing be held on
806 the application. Any request for a public hearing shall be made to the
807 office not later than thirty days after the date the office determines the
808 application to be complete.

809 (f) (1) The office shall hold a public hearing [with respect to each] on
810 a properly filed and completed certificate of need application [filed
811 pursuant to section 19a-638 after December 1, 2015,] that concerns any
812 transfer of ownership [involving] of a hospital. Such hearing shall be
813 held in the municipality in which the hospital that is the subject of the
814 application is located.

815 (2) The office may hold a public hearing with respect to any
816 certificate of need application submitted under this chapter. The office
817 shall provide not less than [two] three weeks' advance notice to the
818 applicant, in writing, and the applicant shall provide not less than two

819 weeks' advance notice to the public by (A) publication in a newspaper
820 having a substantial circulation in the area served by the health care
821 facility or provider, and (B) requesting publication in at least two sites
822 within the affected community that are commonly accessed by the
823 public, such as a town hall or library and on any existing Internet web
824 site of the municipality or local health department. In conducting its
825 activities under this chapter, the office may hold a public hearing on
826 applications of a similar nature at the same time.

827 (g) If the certificate of need application involves the transfer of
828 ownership of a hospital, the applicant shall include in a single
829 application all information related to all supplemental transactions
830 associated with such transfer of ownership that would otherwise
831 require a separate certificate of need application. Any such application
832 shall be subject to a cost and market impact review pursuant to section
833 19a-639f, as amended by this act.

834 (h) The office may retain an independent consultant with expertise
835 in the specific area of health care that is the subject of a pending
836 application filed by an applicant if the review and analysis of an
837 application cannot reasonably be conducted by the office without the
838 expertise of an industry analyst or other actuarial consultant. Upon a
839 determination by the office that an independent consultant is required,
840 the applicant shall establish an escrow account pursuant to a formal
841 escrow agreement provided by the office for the purpose of paying the
842 bills for services provided by the independent consultant. The
843 applicant shall initially fund the escrow account in an amount to be
844 determined by the office, not to exceed twenty thousand dollars. The
845 office shall submit bills for independent consultant services to the
846 applicant. The escrow agent shall pay such bills out of the escrow
847 account directly to the independent consultant not later than thirty
848 days after receipt of each bill by the applicant. Such bills shall not
849 exceed twenty thousand dollars per application. The provisions of
850 chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not
851 apply to any agreement executed pursuant to this subsection.

852 [(g)] (i) The Commissioner of Public Health may implement policies
853 and procedures necessary to administer the provisions of this section
854 while in the process of adopting such policies and procedures as
855 regulation, provided the commissioner holds a public hearing prior to
856 implementing the policies and procedures and prints notice of intent to
857 adopt regulations on the department's Internet web site and the
858 eRegulations System not later than twenty days after the date of
859 implementation. Policies and procedures implemented pursuant to
860 this section shall be valid until the time final regulations are adopted.

861 Sec. 8. Subsection (e) of section 19a-639b of the general statutes is
862 repealed and the following is substituted in lieu thereof (*Effective July*
863 *1, 2017*):

864 (e) The Commissioner of Public Health may implement policies and
865 procedures necessary to administer the provisions of this section while
866 in the process of adopting such policies and procedures as regulation,
867 provided the commissioner holds a public hearing prior to
868 implementing the policies and procedures and prints notice of intent to
869 adopt regulations in the Connecticut Law Journal not later than twenty
870 days after the date of implementation. Policies and procedures
871 implemented pursuant to this section shall be valid until the time final
872 regulations are adopted. [Final regulations shall be adopted by
873 December 31, 2011.]

874 Sec. 9. Section 19a-639c of the general statutes is repealed and the
875 following is substituted in lieu thereof (*Effective July 1, 2017*):

876 (a) Any health care facility that proposes to relocate a facility shall
877 submit a [letter] determination request to the office [, as described in
878 subsection (c) of section 19a-638. In addition to the requirements
879 prescribed in said subsection (c), in such letter the health care facility
880 shall demonstrate] that describes the project and demonstrates to the
881 satisfaction of the office that the population served by the health care
882 facility and the payer mix will not substantially change as a result of
883 the facility's proposed relocation. If the facility is unable to

884 demonstrate to the satisfaction of the office that the population served
885 and the payer mix will not substantially change as a result of the
886 proposed relocation, the health care facility shall apply for certificate of
887 need approval pursuant to subdivision (1) of subsection (a) of section
888 19a-638, as amended by this act, in order to effectuate the proposed
889 relocation.

890 (b) The Commissioner of Public Health may implement policies and
891 procedures necessary to administer the provisions of this section while
892 in the process of adopting such policies and procedures as regulation,
893 provided the commissioner holds a public hearing prior to
894 implementing the policies and procedures and prints notice of intent to
895 adopt regulations in the Connecticut Law Journal not later than twenty
896 days after the date of implementation. Policies and procedures
897 implemented pursuant to this section shall be valid until the time final
898 regulations are adopted. [Final regulations shall be adopted by
899 December 31, 2011.]

900 Sec. 10. Section 19a-639e of the general statutes is repealed and the
901 following is substituted in lieu thereof (*Effective July 1, 2017*):

902 (a) [Unless otherwise required to file a certificate of need application
903 pursuant to the provisions of subsection (a) of section 19a-638, any
904 health care facility that proposes to terminate a service that was
905 authorized pursuant to a certificate of need issued under this chapter
906 shall file a modification request with] Any hospital or hospital system
907 proposing to terminate or reduce inpatient or outpatient services due
908 to insufficient patient volume or the lack of practitioners to support the
909 effective delivery of care, as specified in subdivision (5) of subsection
910 (a) of section 19a-638, as amended by this act, shall submit a
911 determination request to the office not later than sixty days prior to the
912 proposed date of [the] such termination or reduction of the service.
913 Such request shall include (1) the date on which the service or services
914 will be terminated or reduced by the hospital or hospital system, (2)
915 documentation that demonstrates that the hospital or hospital system
916 is experiencing insufficient patient volume or lack of practitioners for

917 the service, resulting in such hospital or hospital system being unable
918 to support effective delivery of care, and (3) whether the termination
919 or reduction of service will occur in a geographic area that has been
920 identified in the state-wide health care facilities and services plan as
921 being underserved or having reduced access to specific types of health
922 care services. Any hospital or hospital system that is unable to
923 demonstrate to the satisfaction of the office that the proposed
924 termination or reduction is due to insufficient patient volume or the
925 lack of practitioners to support the effective delivery of care shall be
926 required to file a certificate of need pursuant to subsection (a) of
927 section 19a-638, as amended by this act. The office may request
928 additional information from [the health care facility] such hospital or
929 hospital system as necessary to process the [modification] request. [In
930 addition, the office shall hold a public hearing on any request from a
931 health care facility to terminate a service pursuant to this section if
932 three or more individuals or an individual representing an entity with
933 five or more people submits a request, in writing, that a public hearing
934 be held on the health care facility's proposal to terminate a service.

935 (b) Unless otherwise required to file a certificate of need application
936 pursuant to the provisions of subsection (a) of section 19a-638, any
937 health care facility that proposes to terminate all services offered by
938 such facility, that were authorized pursuant to one or more certificates
939 of need issued under this chapter, shall provide notification to the
940 office not later than sixty days prior to the termination of services and
941 such facility shall surrender its certificate of need not later than thirty
942 days prior to the termination of services.]

943 (b) Any person, physician, provider or hospital proposing to acquire
944 a scanner that utilizes imaging techniques, including, but not limited
945 to, computed tomography, magnetic resonance imaging, positron
946 emission tomography, positron emission tomography-computed
947 tomography or single-photon emission computed tomography shall
948 submit a determination request to the office not later than sixty days
949 prior to the proposed date of the acquisition of the equipment, unless

950 such proposed acquisition is for the purpose of replacing an existing
951 scanner with a similar scanner, if such existing scanner was acquired
952 through a certificate of need approval or a certificate of need
953 determination, provided a person, physician, provider or hospital
954 notifies the office of the date on which the scanner is replaced and the
955 disposition of the replaced scanner. Such request shall include (1) the
956 date on which the equipment is to be acquired, (2) the methods such
957 person, physician, provider or hospital will utilize to minimize the
958 practice of patient referrals in which the referring provider will stand
959 to financially gain from such referral, (3) demonstration that Medicaid
960 recipients and indigent persons will have access to the services
961 provided utilizing the equipment acquired, and (4) whether the
962 equipment will be utilized in a geographic area that has been
963 identified in the state-wide health care facilities and services plan as
964 being underserved or having reduced access to specific types of health
965 care services. Any person, physician, provider or hospital that fails to
966 sufficiently demonstrate to the satisfaction of the office that methods
967 will be utilized to minimize the practice of patient referrals in which
968 the referring provider will stand to financially gain from such referral
969 and that Medicaid recipients and indigent persons will have access to
970 the services provided utilizing the equipment acquired shall be
971 required to file a certificate of need pursuant to subsection (a) of
972 section 19a-638, as amended by this act. The office may request
973 additional information from such person, physician, provider or
974 hospital as necessary to process the request.

975 (c) Any person proposing to establish a new hospital, new
976 freestanding emergency department or new outpatient surgical facility
977 in areas identified in the state-wide health care facilities and services
978 plan as underserved or having reduced access to specific types of
979 health care services shall submit a determination request to the office
980 not later than sixty days prior to the proposed establishment of such
981 new health care facility. Such request shall include (1) the date on
982 which such new health care facility is proposed to be operational, (2) a
983 demonstration that the new health care facility will be located in a

984 geographic area that has been identified in the state-wide health care
985 facilities and services plan as being underserved or having reduced
986 access to specific types of health care services, and (3) a demonstration
987 that Medicaid recipients and indigent persons will have access to the
988 services provided. Any person submitting a determination request that
989 fails to sufficiently demonstrate to the satisfaction of the office that
990 such new health care facility will be located in a geographic area that
991 has been identified in the state-wide health care facilities and services
992 plan as being underserved or having reduced access to specific types
993 of health care services and will serve Medicaid recipients and indigent
994 persons shall be required to file a certificate of need pursuant to
995 subsection (a) of section 19a-638, as amended by this act. The office
996 may request additional information from such person as necessary to
997 process the request.

998 [(c)] (d) Unless otherwise required to file a certificate of need
999 application pursuant to the provisions of subsection (a) of section 19a-
1000 638, as amended by this act, any health care facility that proposes to
1001 terminate the operation of a facility or service [for which a certificate of
1002 need was not obtained] shall notify the office not later than sixty days
1003 prior to terminating the operation of the facility or service. Such
1004 notification shall include (1) the name and location of the health care
1005 facility, (2) the reason for terminating the operation of the health care
1006 facility or service, (3) other locations where patients may be able to
1007 obtain the services that are provided by the health care facility that
1008 intends to terminate its operation or services, and (4) the date the
1009 health care facility will be terminating its operation or service
1010 definition.

1011 [(d)] (e) The Commissioner of Public Health may adopt regulations,
1012 in accordance with chapter 54, to implement the provisions of this
1013 section. In addition, the commissioner may implement policies and
1014 procedures necessary to administer the provisions of this section while
1015 in the process of adopting such policies and procedures as regulation,
1016 provided the commissioner holds a public hearing prior to

1017 implementing the policies and procedures and prints notice of intent to
1018 adopt regulations in the Connecticut Law Journal not later than twenty
1019 days after the date of implementation. Policies and procedures
1020 implemented pursuant to this section shall be valid until the time final
1021 regulations are adopted. [Final regulations shall be adopted by
1022 December 31, 2015.]

1023 Sec. 11. Section 19a-639f of the general statutes is repealed and the
1024 following is substituted in lieu thereof (*Effective July 1, 2017*):

1025 (a) For purposes of this section:

1026 (1) "Dispersed service area" means a geographic area in which a
1027 provider organization delivers health care services (A) based on the
1028 number of zip codes, towns, counties or primary service areas in such
1029 geographic area, and (B) the standards of which may vary based upon
1030 the population density of such geographic area as compared to the
1031 various other regions of the state.

1032 (2) "Health status adjusted total medical expense" means a measure
1033 of the total cost of care, adjusted by health status, for the patient
1034 population associated with a provider group, which may be (A)
1035 calculated based on allowed claims for all categories of medical
1036 expenses and all non-claims-related payments to providers, and (B)
1037 expressed on a per member per month basis.

1038 (3) "Major service category" means a set of service categories that
1039 may include (A) acute hospital inpatient services, by Medicare
1040 Severity-Diagnosis Related Groups, (B) outpatient and ambulatory
1041 services, by categories as defined by the federal Centers for Medicare
1042 and Medicaid, and (C) behavioral, substance use disorder and mental
1043 health services, by categories as defined by the federal Centers for
1044 Medicare and Medicaid.

1045 (4) "Relative prices" means a measure that (A) compares amounts
1046 paid to a provider relative to other providers for the same health care
1047 services, and (B) may be calculated based on the contractually

1048 negotiated amounts paid to providers by each private and public
1049 health carrier for health care services, including, but not limited to,
1050 non-claims-related payments, and expressed in the aggregate relative
1051 to the payer's network-wide average amount paid to providers.

1052 (5) "Total health care spending" means a measure of all health care
1053 expenditures in the state from public and private sources, including
1054 (A) all categories of medical expenses and all non-claims-related
1055 payments to providers, (B) all patient cost-sharing amounts, including,
1056 but not limited to, deductibles and copayments, and (C) the net cost of
1057 private health insurance, which may be expressed as an annual per
1058 capita sum.

1059 [(a)] (b) The Office of Healthcare Access division within the
1060 Department of Public Health shall conduct a cost and market impact
1061 review in each case where (1) an application for a certificate of need
1062 filed pursuant to section 19a-638, as amended by this act, involves the
1063 transfer of ownership of a hospital, [as defined in section 19a-639,] and
1064 (2) the purchaser is a hospital, [as defined in section 19a-490,] whether
1065 located within or outside the state, that had net patient revenue for
1066 fiscal year 2013 in an amount greater than one billion five hundred
1067 million dollars, or a hospital system, [as defined in section 19a-486i,]
1068 whether located within or outside the state, that had net patient
1069 revenue for fiscal year 2013 in an amount greater than one billion five
1070 hundred million dollars or any person that is organized or operated
1071 for profit.

1072 [(b)] (c) Not later than twenty-one days after receipt of a properly
1073 filed certificate of need application involving the transfer of ownership
1074 of a hospital [filed on or after December 1, 2015, as described in
1075 subsection (a) of this section,] the office shall initiate such cost and
1076 market impact review by sending the transacting parties a written
1077 notice that shall contain a description of the basis for the cost and
1078 market impact review as well as a request for information and
1079 documents. Not later than thirty days after receipt of such notice, the
1080 transacting parties shall submit to the office a written response. Such

1081 response shall include, but need not be limited to, any information or
1082 documents requested by the office concerning the transfer of
1083 ownership of the hospital. The office shall have the powers with
1084 respect to the cost and market impact review as provided in section
1085 19a-633.

1086 ~~[(c)]~~ (d) The office shall keep confidential all nonpublic information
1087 and documents obtained pursuant to this section and shall not disclose
1088 the information or documents to any person without the consent of the
1089 person that produced the information or documents, except in a
1090 preliminary report or final report issued in accordance with this
1091 section if the office believes that such disclosure should be made in the
1092 public interest after taking into account any privacy, trade secret or
1093 anti-competitive considerations. Such information and documents
1094 shall not be deemed a public record, under section 1-210, and shall be
1095 exempt from disclosure.

1096 ~~[(d)]~~ (e) The cost and market impact review conducted pursuant to
1097 this section shall examine factors relating to the businesses and relative
1098 market positions of the transacting parties as defined in [subsection (d)
1099 of section 19a-639] section 19a-630, as amended by this act, and may
1100 include, but need not be limited to: (1) The transacting parties' size and
1101 market share within its primary service area, by major service category
1102 and within its dispersed service areas; (2) the transacting parties' prices
1103 for services, including the transacting parties' relative prices compared
1104 to other health care providers for the same services in the same market;
1105 (3) the transacting parties' health status adjusted total medical expense,
1106 including the transacting parties' health status adjusted total medical
1107 expense compared to that of similar health care providers; (4) the
1108 quality of the services provided by the transacting parties, including
1109 patient experience; (5) the transacting parties' cost and cost trends in
1110 comparison to total health care expenditures state wide; (6) the
1111 availability and accessibility of services similar to those provided by
1112 each transacting party, or proposed to be provided as a result of the
1113 transfer of ownership [of a hospital] within each transacting party's

1114 primary service areas and dispersed service areas; (7) the impact of the
1115 proposed transfer of ownership [of the hospital] on competing options
1116 for the delivery of health care services within each transacting party's
1117 primary service area and dispersed service area including the impact
1118 on existing service providers; (8) the methods used by the transacting
1119 parties to attract patient volume and to recruit or acquire health care
1120 professionals or facilities; (9) the role of each transacting party in
1121 serving at-risk, underserved and government payer patient
1122 populations, including those with behavioral, substance use disorder
1123 and mental health conditions, within each transacting party's primary
1124 service area and dispersed service area; (10) the role of each transacting
1125 party in providing low margin or negative margin services within each
1126 transacting party's primary service area and dispersed service area;
1127 (11) consumer concerns, including, but not limited to, complaints or
1128 other allegations that a transacting party has engaged in any unfair
1129 method of competition or any unfair or deceptive act or practice; and
1130 (12) any other factors that the office determines to be in the public
1131 interest.

1132 [(e)] (f) Not later than ninety days after the office determines that
1133 there is substantial compliance with any request for documents or
1134 information issued by the office in accordance with this section, or a
1135 later date set by mutual agreement of the office and the transacting
1136 parties, the office shall make factual findings and issue a preliminary
1137 report on the cost and market impact review. Such preliminary report
1138 shall include, but shall not be limited to, an indication as to whether a
1139 transacting party meets the following criteria: (1) Currently has or,
1140 following the proposed transfer of operations of the hospital, is likely
1141 to have a dominant market share for the services the transacting party
1142 provides; and (2) (A) currently charges or, following the proposed
1143 transfer of operations of the hospital, is likely to charge prices for
1144 services that are materially higher than the median prices charged by
1145 all other health care providers for the same services in the same
1146 market, or (B) currently has or, following the proposed transfer of
1147 operations of a hospital, is likely to have a health status adjusted total

1148 medical expense that is materially higher than the median total
1149 medical expense for all other health care providers for the same service
1150 in the same market.

1151 ~~[(f)]~~ (g) The transacting parties that are the subject of the cost and
1152 market impact review may respond in writing to the findings in the
1153 preliminary report issued in accordance with subsection ~~[(e)]~~ (f) of this
1154 section not later than thirty days after the issuance of the preliminary
1155 report. Not later than sixty days after the issuance of the preliminary
1156 report, the office shall issue a final report of the cost and market impact
1157 review. The office shall refer to the Attorney General any final report
1158 on any proposed transfer of ownership that meets the criteria
1159 described in subsection ~~[(e)]~~ (f) of this section.

1160 ~~[(g)]~~ (h) Nothing in this section shall prohibit a transfer of
1161 ownership of a hospital, provided any such proposed transfer shall not
1162 be completed (1) less than thirty days after the office has issued a final
1163 report on a cost and market impact review, if such review is required,
1164 or (2) while any action brought by the Attorney General pursuant to
1165 subsection ~~[(h)]~~ (i) of this section is pending and before a final
1166 judgment on such action is issued by a court of competent jurisdiction.

1167 ~~[(h)]~~ (i) After the office refers a final report on a transfer of
1168 ownership of a hospital to the Attorney General under subsection ~~[(f)]~~
1169 (g) of this section, the Attorney General may: (1) Conduct an
1170 investigation to determine whether the transacting parties engaged, or,
1171 as a result of completing the transfer of ownership of the hospital, are
1172 expected to engage in unfair methods of competition, anti-competitive
1173 behavior or other conduct in violation of chapter 624 or 735a or any
1174 other state or federal law; and (2) if appropriate, take action under
1175 chapter 624 or 735a or any other state law to protect consumers in the
1176 health care market. The office's final report may be evidence in any
1177 such action.

1178 ~~[(i)]~~ (j) For the purposes of this section, the provisions of chapter
1179 735a may be directly enforced by the Attorney General. Nothing in this

1180 section shall be construed to modify, impair or supersede the
1181 operation of any state antitrust law or otherwise limit the authority of
1182 the Attorney General to (1) take any action against a transacting party
1183 as authorized by any law, or (2) protect consumers in the health care
1184 market under any law. Notwithstanding subdivision (1) of subsection
1185 (a) of section 42-110c, the transacting parties shall be subject to chapter
1186 735a.

1187 ~~[(j)]~~ [(k)] The office shall retain an independent consultant with
1188 expertise on the economic analysis of the health care market and health
1189 care costs and prices to conduct each cost and market impact review,
1190 as described in this section. [The office shall submit bills for such
1191 services to the purchaser, as defined in subsection (d) of section 19a-
1192 639. Such purchaser] Upon the filing of an application involving the
1193 transfer of ownership of a hospital, the purchaser shall establish an
1194 escrow account pursuant to a formal escrow agreement provided by
1195 the Office of Health Care Access for the purpose of paying the bills for
1196 services provided by the independent consultant. The purchaser shall
1197 initially fund the escrow account with two hundred thousand dollars.
1198 The office shall submit bills for independent consultant services to the
1199 purchaser, as defined in section 19a-630, as amended by this act. The
1200 escrow agent shall pay such bills out of the escrow account directly to
1201 the independent consultant not later than thirty days after receipt of
1202 each bill by the purchaser. Such bills shall not exceed two hundred
1203 thousand dollars per application. The provisions of chapter 57, sections
1204 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any
1205 agreement executed pursuant to this subsection.

1206 ~~[(k)]~~ [(l)] Any employee of the office who directly oversees or assists
1207 in conducting a cost and market impact review shall not take part in
1208 factual deliberations or the issuance of a preliminary or final decision
1209 on the certificate of need application concerning the transfer of
1210 ownership [of a hospital] that is the subject of such cost and market
1211 impact review.

1212 ~~[(l)]~~ [(m)] The Commissioner of Public Health shall adopt regulations,

1213 in accordance with the provisions of chapter 54, concerning cost and
1214 market impact reviews and to administer the provisions of this section.
1215 [Such regulations shall include definitions of the following terms:
1216 "Dispersed service area", "health status adjusted total medical
1217 expense", "major service category", "relative prices", "total health care
1218 spending" and "health care services".] The commissioner may
1219 implement policies and procedures necessary to administer the
1220 provisions of this section while in the process of adopting such policies
1221 and procedures in regulation form, provided the commissioner
1222 publishes notice of intention to adopt the regulations on the
1223 Department of Public Health's Internet web site and the eRegulations
1224 System not later than twenty days after implementing such policies
1225 and procedures. Policies and procedures implemented pursuant to this
1226 subsection shall be valid until the time such regulations are effective.

1227 Sec. 12. Section 19a-653 of the general statutes is repealed and the
1228 following is substituted in lieu thereof (*Effective July 1, 2017*):

1229 (a) [Any] The Department of Public Health may impose a civil
1230 penalty of up to one thousand dollars per day on any person or health
1231 care facility or institution that [is required to] negligently fails to (1) file
1232 a certificate of need for any of the activities described in section 19a-
1233 638, [and any person or health care facility or institution that is
1234 required to] as amended by this act, for each day such activities are
1235 conducted without the certificate of need approval, (2) file data or
1236 information under any public or special act or under this chapter or
1237 sections 19a-486 to 19a-486h, inclusive, or any regulation adopted or
1238 order issued under this chapter or said sections [, which wilfully fails
1239 to seek certificate of need approval for any of the activities described in
1240 section 19a-638 or to so file within prescribed time periods, shall be
1241 subject to a civil penalty of up to one thousand dollars a day for each
1242 day such person or health care facility or institution conducts any of
1243 the described activities without certificate of need approval as required
1244 by section 19a-638 or for each day such information is missing,
1245 incomplete or inaccurate] within prescribed time periods, for each day

1246 such data or information is missing, incomplete or inaccurate, or (3)
1247 comply with a condition in accordance with subsection (h) of section
1248 19a-639, as amended by this act, for each day such condition is
1249 breached. Any civil penalty authorized by this section shall be
1250 imposed by the Department of Public Health in accordance with
1251 subsections (b) to (e), inclusive, of this section.

1252 (b) If the Department of Public Health has reason to believe that a
1253 violation has occurred for which a civil penalty is authorized by
1254 subsection (a) of this section or subsection (e) of section 19a-632, it shall
1255 notify the person or health care facility or institution by first-class mail
1256 or personal service. The notice shall include: (1) A reference to the
1257 sections of the statute or regulation involved; (2) a short and plain
1258 statement of the matters asserted or charged; (3) a statement of the
1259 amount of the civil penalty or penalties to be imposed; (4) the initial
1260 date of the imposition of the penalty; and (5) a statement of the party's
1261 right to a hearing.

1262 (c) The person or health care facility or institution to whom the
1263 notice is addressed shall have fifteen business days from the date of
1264 mailing of the notice to make written application to the office to
1265 request (1) a hearing to contest the imposition of the penalty, or (2) an
1266 extension of time to file the required data. A failure to make a timely
1267 request for a hearing or an extension of time to file the required data or
1268 a denial of a request for an extension of time shall result in a final order
1269 for the imposition of the penalty. All hearings under this section shall
1270 be conducted pursuant to sections 4-176e to 4-184, inclusive. The
1271 Department of Public Health may grant an extension of time for filing
1272 the required data or mitigate or waive the penalty upon such terms
1273 and conditions as, in its discretion, it deems proper or necessary upon
1274 consideration of any extenuating factors or circumstances.

1275 (d) A final order of the Department of Public Health assessing a civil
1276 penalty shall be subject to appeal as set forth in section 4-183 after a
1277 hearing before the office pursuant to subsection (c) of this section,
1278 except that any such appeal shall be taken to the superior court for the

1279 judicial district of New Britain. Such final order shall not be subject to
1280 appeal under any other provision of the general statutes. No challenge
1281 to any such final order shall be allowed as to any issue which could
1282 have been raised by an appeal of an earlier order, denial or other final
1283 decision by the Department of Public Health.

1284 (e) If any person or health care facility or institution fails to pay any
1285 civil penalty under this section, after the assessment of such penalty
1286 has become final the amount of such penalty may be deducted from
1287 payments to such person or health care facility or institution from the
1288 Medicaid account.

1289 Sec. 13. Subsection (a) of section 19a-486d of the general statutes is
1290 repealed and the following is substituted in lieu thereof (*Effective July*
1291 *1, 2017*):

1292 (a) The commissioner shall deny an application filed pursuant to
1293 subsection (d) of section 19a-486a unless the commissioner finds that:
1294 (1) In a situation where the asset or operation to be transferred
1295 provides or has provided health care services to the uninsured or
1296 underinsured, the purchaser has made a commitment to provide
1297 health care to the uninsured and the underinsured; (2) in a situation
1298 where health care providers or insurers will be offered the opportunity
1299 to invest or own an interest in the purchaser or an entity related to the
1300 purchaser safeguard procedures are in place to avoid a conflict of
1301 interest in patient referral; and (3) certificate of need authorization is
1302 justified in accordance with chapter 368z. The commissioner may
1303 contract with any person, including, but not limited to, financial or
1304 actuarial experts or consultants, or legal experts with the approval of
1305 the Attorney General, to assist in reviewing the completed application.
1306 The commissioner shall submit any bills for such contracts to the
1307 purchaser. Such bills shall not exceed one hundred fifty thousand
1308 dollars. [The purchaser] Upon the filing of an application pursuant to
1309 subsection (d) of section 19a-486a, the purchaser shall establish an
1310 escrow account pursuant to a formal escrow agreement provided by
1311 the Office of Health Care Access for the purpose of paying bills for

1312 services provided by the consultant. The purchaser shall initially fund
1313 the escrow account with one hundred fifty thousand dollars. The
1314 escrow agent shall pay such bills [no] out of the escrow account
1315 directly to the expert or consultant not later than thirty days after the
1316 date of receipt of [such bills] each bill by the purchaser.

1317 Sec. 14. Section 19a-486i of the general statutes is repealed and the
1318 following is substituted in lieu thereof (*Effective July 1, 2017*):

1319 (a) As used in this section:

1320 (1) "Affiliation" means the formation of a relationship between two
1321 or more entities that permits the entities to negotiate jointly with third
1322 parties over rates for professional medical services;

1323 (2) "Captive professional entity" means a partnership, professional
1324 corporation, limited liability company or other entity formed to render
1325 professional services in which a partner, a member, a shareholder or a
1326 beneficial owner is a physician, directly or indirectly, employed by,
1327 controlled by, subject to the direction of, or otherwise designated by
1328 (A) a hospital, (B) a hospital system, (C) a medical school, (D) a
1329 medical foundation, organized pursuant to subsection (a) of section 33-
1330 182bb, or (E) any entity that controls, is controlled by or is under
1331 common control with, whether through ownership, governance,
1332 contract or otherwise, another person, entity or organization described
1333 in subparagraphs (A) to (D), inclusive, of this subdivision;

1334 (3) "Hospital" has the same meaning as provided in section [19a-490]
1335 19a-646;

1336 (4) "Hospital system" means: (A) A parent corporation of one or
1337 more hospitals and any entity affiliated with such parent corporation
1338 through ownership, governance or membership; [,] or (B) a hospital
1339 and any entity affiliated with such hospital through ownership,
1340 governance or membership;

1341 (5) "Health care provider" has the same meaning as provided in

1342 section 19a-17b;

1343 (6) "Medical foundation" means a medical foundation formed under
1344 chapter 594b;

1345 (7) "Physician" has the same meaning as provided in section 20-13a;

1346 (8) "Person" has the same meaning as provided in section 35-25;

1347 (9) "Professional corporation" has the same meaning as provided in
1348 section 33-182a;

1349 (10) "Group practice" means two or more physicians, legally
1350 organized in a partnership, professional corporation, limited liability
1351 company formed to render professional services, medical foundation,
1352 not-for-profit corporation, faculty practice plan or other similar entity
1353 (A) in which each physician who is a member of the group provides
1354 substantially the full range of services that the physician routinely
1355 provides, including, but not limited to, medical care, consultation,
1356 diagnosis or treatment, through the joint use of shared office space,
1357 facilities, equipment or personnel; (B) for which substantially all of the
1358 services of the physicians who are members of the group are provided
1359 through the group and are billed in the name of the group practice and
1360 amounts so received are treated as receipts of the group; or (C) in
1361 which the overhead expenses of, and the income from, the group are
1362 distributed in accordance with methods previously determined by
1363 members of the group. An entity that otherwise meets the definition of
1364 group practice under this section shall be considered a group practice
1365 although its shareholders, partners or owners of the group practice
1366 include single-physician professional corporations, limited liability
1367 companies formed to render professional services or other entities in
1368 which beneficial owners are individual physicians; and

1369 (11) "Primary service area" means the smallest number of zip codes
1370 from which the group practice draws at least seventy-five per cent of
1371 its patients.

1372 (b) At the same time that any person conducting business in this
1373 state that files merger, acquisition or any other information regarding
1374 market concentration with the Federal Trade Commission or the
1375 United States Department of Justice, in compliance with the Hart-
1376 Scott-Rodino Antitrust Improvements Act, 15 USC 18a, where a
1377 hospital, hospital system or other health care provider is a party to the
1378 merger or acquisition that is the subject of such information, such
1379 person shall provide written notification to the Attorney General of
1380 such filing and, upon the request of the Attorney General, provide a
1381 copy of such merger, acquisition or other information.

1382 (c) Not less than thirty days prior to the effective date of any
1383 transaction that results in a material change to the business or
1384 corporate structure of a group practice, the parties to the transaction
1385 shall submit written notice to the Attorney General of such material
1386 change. For purposes of this subsection, a material change to the
1387 business or corporate structure of a group practice includes: (1) The
1388 merger, consolidation or other affiliation of a group practice with (A)
1389 another group practice that results in a group practice comprised of
1390 eight or more physicians, or (B) a hospital, hospital system, captive
1391 professional entity, medical foundation or other entity organized or
1392 controlled by such hospital or hospital system; (2) the acquisition of all
1393 or substantially all of (A) the properties and assets of a group practice,
1394 or (B) the capital stock, membership interests or other equity interests
1395 of a group practice by (i) another group practice that results in a group
1396 practice comprised of eight or more physicians, or (ii) a hospital,
1397 hospital system, captive professional entity, medical foundation or
1398 other entity organized or controlled by such hospital or hospital
1399 system; (3) the employment of all or substantially all of the physicians
1400 of a group practice by (A) another group practice that results in a
1401 group practice comprised of eight or more physicians, or (B) a hospital,
1402 hospital system, captive professional entity, medical foundation or
1403 other entity organized by, controlled by or otherwise affiliated with
1404 such hospital or hospital system; and (4) the acquisition of one or more
1405 insolvent group practices by (A) another group practice that results in

1406 a group practice comprised of eight or more physicians, or (B) a
1407 hospital, hospital system, captive professional entity, medical
1408 foundation or other entity organized by, controlled by or otherwise
1409 affiliated with such hospital or hospital system.

1410 (d) (1) The written notice required under subsection (c) of this
1411 section shall identify each party to the transaction and describe the
1412 material change as of the date of such notice to the business or
1413 corporate structure of the group practice, including: (A) A description
1414 of the nature of the proposed relationship among the parties to the
1415 proposed transaction; (B) the names and specialties of each physician
1416 that is a member of the group practice that is the subject of the
1417 proposed transaction and who will practice medicine with the
1418 resulting group practice, hospital, hospital system, captive professional
1419 entity, medical foundation or other entity organized by, controlled by,
1420 or otherwise affiliated with such hospital or hospital system following
1421 the effective date of the transaction; (C) the names of the business
1422 entities that are to provide services following the effective date of the
1423 transaction; (D) the address for each location where such services are
1424 to be provided; (E) a description of the services to be provided at each
1425 such location; and (F) the primary service area to be served by each
1426 such location.

1427 (2) Not later than thirty days after the effective date of any
1428 transaction described in subsection (c) of this section, the parties to the
1429 transaction shall submit written notice to the Commissioner of Public
1430 Health. Such written notice shall include, but need not be limited to,
1431 the same information described in subdivision (1) of this subsection.
1432 The commissioner shall post a link to such notice on the Department of
1433 Public Health's Internet web site.

1434 (e) Not less than thirty days prior to the effective date of any
1435 transaction that results in an affiliation between one hospital or
1436 hospital system and another hospital or hospital system, the parties to
1437 the affiliation shall submit written notice to the Attorney General of
1438 such affiliation. Such written notice shall identify each party to the

1439 affiliation and describe the affiliation as of the date of such notice,
1440 including: (1) A description of the nature of the proposed relationship
1441 among the parties to the affiliation; (2) the names of the business
1442 entities that are to provide services following the effective date of the
1443 affiliation; (3) the address for each location where such services are to
1444 be provided; (4) a description of the services to be provided at each
1445 such location; and (5) the primary service area to be served by each
1446 such location.

1447 (f) Written information submitted to the Attorney General pursuant
1448 to subsections (b) to (e), inclusive, of this section shall be maintained
1449 and used by the Attorney General in the same manner as provided in
1450 section 35-42.

1451 (g) Not later than [December 31, 2014] January 15, 2018, and
1452 annually thereafter, each hospital and hospital system shall file with
1453 the Attorney General and the Commissioner of Public Health a written
1454 report describing the activities of the group practices owned or
1455 affiliated with such hospital or hospital system. Such report shall
1456 include, for each such group practice: (1) A description of the nature of
1457 the relationship between the hospital or hospital system and the group
1458 practice; (2) the names and specialties of each physician practicing
1459 medicine with the group practice; (3) the names of the business entities
1460 that provide services as part of the group practice and the address for
1461 each location where such services are provided; (4) a description of the
1462 services provided at each such location; and (5) the primary service
1463 area served by each such location.

1464 (h) Not later than [December 31, 2014] January 15, 2018, and
1465 annually thereafter, each group practice comprised of thirty or more
1466 physicians that is not the subject of a report filed under subsection (g)
1467 of this section shall file with the Attorney General and the
1468 Commissioner of Public Health a written report concerning the group
1469 practice. Such report shall include, for each such group practice: (1)
1470 The names and specialties of each physician practicing medicine with
1471 the group practice; (2) the names of the business entities that provide

1472 services as part of the group practice and the address for each location
1473 where such services are provided; (3) a description of the services
1474 provided at each such location; and (4) the primary service area served
1475 by each such location.

1476 (i) Not later than [December 31, 2015] January 15, 2018, and
1477 annually thereafter, each hospital and hospital system shall file with
1478 the Attorney General and the Commissioner of Public Health a written
1479 report describing each affiliation with another hospital or hospital
1480 system. Such report shall include: (1) The name and address of each
1481 party to the affiliation; (2) a description of the nature of the
1482 relationship among the parties to the affiliation; (3) the names of the
1483 business entities that provide services as part of the affiliation and the
1484 address for each location where such services are provided; (4) a
1485 description of the services provided at each such location; and (5) the
1486 primary service area served by each such location.

1487 Sec. 15. Subsections (a) to (c), inclusive, of section 17b-352 of the
1488 general statutes are repealed and the following is substituted in lieu
1489 thereof (*Effective July 1, 2017*):

1490 (a) For the purposes of this section and section 17b-353, as amended
1491 by this act, "facility" means a residential facility for persons with
1492 intellectual disability licensed pursuant to section 17a-277 and certified
1493 to participate in the Title XIX Medicaid program as an intermediate
1494 care facility for individuals with intellectual disabilities, a nursing
1495 home, rest home or residential care home, as defined in section 19a-
1496 490. "Facility" does not include a nursing home that does not
1497 participate in the Medicaid program and is associated with a
1498 continuing care facility as described in section 17b-520.

1499 (b) Any facility which intends to (1) transfer all or part of its
1500 ownership or control prior to being initially licensed; (2) introduce any
1501 additional function or service into its program of care or expand an
1502 existing function or service; [or] (3) terminate a service or decrease
1503 substantially its total bed capacity; or (4) relocate all or a portion of

1504 such facility's licensed beds, to a new facility or replacement facility,
1505 shall submit a complete request for permission to implement such
1506 transfer, addition, expansion, increase, termination, [or] decrease or
1507 relocation of facility beds with such information as the department
1508 requires to the Department of Social Services, provided no permission
1509 or request for permission to close a facility is required when a facility
1510 in receivership is closed by order of the Superior Court pursuant to
1511 section 19a-545. The Office of the Long-Term Care Ombudsman
1512 pursuant to section 17a-405 shall be notified by the facility of any
1513 proposed actions pursuant to this subsection at the same time the
1514 request for permission is submitted to the department and when a
1515 facility in receivership is closed by order of the Superior Court
1516 pursuant to section 19a-545.

1517 (c) An applicant, prior to submitting a certificate of need
1518 application, shall request, in writing, application forms and
1519 instructions from the department. The request shall include: (1) The
1520 name of the applicant or applicants; (2) a statement indicating whether
1521 the application is for (A) a new, additional, expanded or replacement
1522 facility, service or function or relocation of facility beds, (B) a
1523 termination or reduction in a presently authorized service or bed
1524 capacity, or (C) any new, additional or terminated beds and their type;
1525 (3) the estimated capital cost; (4) the town where the project is or will
1526 be located; and (5) a brief description of the proposed project. Such
1527 request shall be deemed a letter of intent. No certificate of need
1528 application shall be considered submitted to the department unless a
1529 current letter of intent, specific to the proposal and in accordance with
1530 the provisions of this subsection, has been on file with the department
1531 for not less than ten business days. For purposes of this subsection, "a
1532 current letter of intent" means a letter of intent on file with the
1533 department for not more than one hundred eighty days. A certificate
1534 of need application shall be deemed withdrawn by the department, if a
1535 department completeness letter is not responded to within one
1536 hundred eighty days. The Office of the Long-Term Care Ombudsman
1537 shall be notified by the facility at the same time as the letter of intent is

1538 submitted to the department.

1539 Sec. 16. Section 17b-353 of the general statutes is repealed and the
1540 following is substituted in lieu thereof (*Effective July 1, 2017*):

1541 (a) Any facility, as defined in subsection (a) of section 17b-352, as
1542 amended by this act, which proposes [(1) a capital expenditure] to
1543 incur (1) capital expenditures exceeding one million dollars, which
1544 increases facility square footage by more than five thousand square
1545 feet or five per cent of the existing square footage, whichever is
1546 greater, [(2) a capital expenditure] or (2) capital expenditures
1547 exceeding two million dollars, [or (3) the acquisition of major medical
1548 equipment requiring a capital expenditure in excess of four hundred
1549 thousand dollars, including the leasing of equipment or space,] shall
1550 submit a request for approval of such expenditure, with such
1551 information as the department requires, to the Department of Social
1552 Services. [Any such facility which proposes to acquire imaging
1553 equipment requiring a capital expenditure in excess of four hundred
1554 thousand dollars, including the leasing of such equipment, shall obtain
1555 the approval of the Office of Health Care Access division of the
1556 Department of Public Health in accordance with the provisions of
1557 chapter 368z, subsequent to obtaining the approval of the
1558 Commissioner of Social Services. Prior to the facility's obtaining the
1559 imaging equipment, the Commissioner of Public Health, after
1560 consultation with the Commissioner of Social Services, may elect to
1561 perform a joint or simultaneous review with the Department of Social
1562 Services.]

1563 (b) An applicant, prior to submitting a certificate of need
1564 application, shall request, in writing, application forms and
1565 instructions from the department. The request shall include: (1) The
1566 name of the applicant or applicants; (2) a statement indicating whether
1567 the application is for (A) a new, additional, expanded or replacement
1568 facility, service or function, (B) a termination or reduction in a
1569 presently authorized service or bed capacity or relocation of facility
1570 beds, or (C) any new, additional or terminated beds and their type; (3)

1571 the estimated capital cost; (4) the town where the project is or will be
1572 located; and (5) a brief description of the proposed project. Such
1573 request shall be deemed a letter of intent. No certificate of need
1574 application shall be considered submitted to the department unless a
1575 current letter of intent, specific to the proposal and in accordance with
1576 the provisions of this subsection, has been on file with the department
1577 for not less than ten business days. For purposes of this subsection, "a
1578 current letter of intent" means a letter of intent on file with the
1579 department for not more than one hundred eighty days. A certificate
1580 of need application shall be deemed withdrawn by the department if a
1581 department completeness letter is not responded to within one
1582 hundred eighty days.

1583 (c) In conducting its activities pursuant to this section, section 17b-
1584 352, as amended by this act, or both, except as provided for in
1585 subsection (d) of this section, the Commissioner of Social Services or
1586 said commissioner's designee may hold a public hearing on an
1587 application or on more than one application, if such applications are of
1588 a similar nature with respect to the request. At least two weeks' notice
1589 of the hearing shall be given to the facility by certified mail and to the
1590 public by publication in a newspaper having a substantial circulation
1591 in the area served by the facility. Such hearing shall be held at the
1592 discretion of the commissioner in Hartford or in the area so served.
1593 The commissioner or the commissioner's designee shall consider such
1594 request in relation to the community or regional need for such capital
1595 program or purchase of land, the possible effect on the operating costs
1596 of the facility and such other relevant factors as the commissioner or
1597 the commissioner's designee deems necessary. In approving or
1598 modifying such request, the commissioner or the commissioner's
1599 designee may not prescribe any condition, such as, but not limited to,
1600 any condition or limitation on the indebtedness of the facility in
1601 connection with a bond issued, the principal amount of any bond
1602 issued or any other details or particulars related to the financing of
1603 such capital expenditure, not directly related to the scope of such
1604 capital program and within the control of the facility. If the hearing is

1605 conducted by a designee of the commissioner, the designee shall
1606 submit any findings and recommendations to the commissioner. The
1607 commissioner shall grant, modify or deny such request within ninety
1608 days, except as provided for in this section. Upon the request of the
1609 applicant, the review period may be extended for an additional fifteen
1610 days if the commissioner or the commissioner's designee has requested
1611 additional information subsequent to the commencement of the review
1612 period. The commissioner or the commissioner's designee may extend
1613 the review period for a maximum of thirty days if the applicant has not
1614 filed in a timely manner information deemed necessary by the
1615 commissioner or the commissioner's designee.

1616 (d) [No] Except as provided in this subsection, no facility shall be
1617 allowed to close or decrease substantially its total bed capacity until
1618 such time as a public hearing has been held in accordance with the
1619 provisions of this subsection and the Commissioner of Social Services
1620 has approved the facility's request unless such decrease is associated
1621 with a census reduction. The commissioner may impose a civil penalty
1622 of not more than five thousand dollars on any facility that fails to
1623 comply with the provisions of this subsection. Penalty payments
1624 received by the commissioner pursuant to this subsection shall be
1625 deposited in the special fund established by the department pursuant
1626 to subsection (c) of section 17b-357 and used for the purposes specified
1627 in said subsection (c). The commissioner or the commissioner's
1628 designee shall hold a public hearing upon the earliest occurrence of: (1)
1629 Receipt of any letter of intent submitted by a facility to the department,
1630 or (2) receipt of any certificate of need application. Such hearing shall
1631 be held at the facility for which the letter of intent or certificate of need
1632 application was submitted not later than thirty days after the date on
1633 which such letter or application was received by the commissioner.
1634 The commissioner or the commissioner's designee shall provide both
1635 the facility and the public with notice of the date of the hearing not less
1636 than fourteen days in advance of such date. Notice to the facility shall
1637 be by certified mail and notice to the public shall be by publication in a
1638 newspaper having a substantial circulation in the area served by the

1639 facility. The provisions of this subsection shall not apply to any
1640 certificate of need approval requested for the relocation of a facility, or
1641 a portion of a facility's licensed beds, to a new or replacement facility.

1642 (e) The Commissioner of Social Services shall adopt regulations, in
1643 accordance with chapter 54, to implement the provisions of this
1644 section. The commissioner shall implement the standards and
1645 procedures of the Office of Health Care Access division of the
1646 Department of Public Health concerning certificates of need
1647 established pursuant to section 19a-643, as appropriate for the
1648 purposes of this section, until the time final regulations are adopted in
1649 accordance with said chapter 54.

1650 Sec. 17. Section 17b-354 of the general statutes is repealed and the
1651 following is substituted in lieu thereof (*Effective July 1, 2017*):

1652 (a) The Department of Social Services shall not accept or approve
1653 any requests for additional nursing home beds, except (1) beds
1654 restricted to use by patients with acquired immune deficiency
1655 syndrome or by patients requiring neurological rehabilitation; (2) beds
1656 associated with a continuing care facility, [which guarantees life care
1657 for its residents] as described in section 17b-520, provided such beds
1658 are not used in the Medicaid program. For the purpose of this
1659 subsection, beds associated with a continuing care facility are not
1660 subject to the certificate of need provisions pursuant to sections 17b-
1661 352 and 17b-353, as amended by this act; (3) Medicaid certified beds to
1662 be relocated from one licensed nursing facility to another licensed
1663 nursing facility to meet a priority need identified in the strategic plan
1664 developed pursuant to subsection (c) of section 17b-369; and (4)
1665 [Medicaid beds to be relocated from a licensed facility or facilities to a
1666 new licensed facility, provided at least one currently licensed facility is
1667 closed in the transaction, and the new facility bed total is not less than
1668 ten per cent lower than the total number of beds relocated. The]
1669 licensed Medicaid nursing facility beds to be relocated from one or
1670 more existing nursing facilities to a new nursing facility, provided (A)
1671 no new Medicaid certified beds are added, (B) at least one currently

1672 licensed facility is closed in the transaction as a result of the relocation,
1673 (C) the new or relocated facility bed total is no more than ninety per
1674 cent of the total number of the licensed beds of the facility from which
1675 such beds shall be relocated and no such relocation shall result in an
1676 increase in state expenditures, (D) the facility participates in the Money
1677 Follows the Person demonstration project pursuant to section 17b-369,
1678 (E) the availability of beds in the area of need will not be adversely
1679 affected, (F) the certificate of need approval for such new facility or
1680 facility relocation and the associated capital expenditures are obtained
1681 pursuant to sections 17b-352 and 17b-353, as amended by this act, and
1682 (G) the facilities included in the bed relocation and closure shall be in
1683 accordance with the strategic plan developed pursuant to subsection
1684 (c) of section 17b-369.], provided (A) the availability of beds in an area
1685 of need will not be adversely affected; and (B) no such relocation shall
1686 result in an increase in state expenditures.

1687 (b) For the purposes of subsection (a) of this section, "a continuing
1688 care facility which guarantees life care for its residents" means: (1) A
1689 facility which does not participate in the Medicaid program; (2) a
1690 facility which establishes its financial stability by submitting to the
1691 commissioner documentation which (A) demonstrates in financial
1692 statements compiled by certified public accountants that the facility
1693 and its direct or indirect owners have (i) on the date of the certificate of
1694 need application and for five years preceding such date, net assets or
1695 reserves equal to or greater than the projected operating revenues for
1696 the facility in its first two years of operation or (ii) assets or other
1697 indications of financial stability determined by the commissioner to be
1698 sufficient to provide for the financial stability of the facility based on
1699 its proposed financial structure and operations, (B) demonstrates in
1700 financial statements compiled by certified public accountants that the
1701 facility, on the date of the certificate of need application, has a
1702 projected debt coverage ratio at ninety-five per cent occupancy of at
1703 least one and twenty-five one-hundredths, (C) details the financial
1704 operation and projected cash flow of the facility on the date of the
1705 certificate of need application, to be updated every five years

1706 thereafter, and demonstrates that fees payable by residents and the
1707 assets, income and insurance coverage of residents, in combination
1708 with other sources of facility funding, are sufficient to provide for the
1709 expenses of life care services for the life of the residents to be made
1710 available within a continuum of care which shall include the provision
1711 of health services in the independent living units, and (D) provides
1712 that any transfer of ownership of the facility to take place within a five-
1713 year period from the date of approval of its certificate of need shall be
1714 subject to the approval of the Commissioner of Social Services in
1715 accordance with the provisions of section 17b-355; (3) a facility which
1716 establishes to the satisfaction of the commissioner that it can provide
1717 for the expenses of the continuum of care to be made available to
1718 residents by complying with the provisions of chapter 319f and
1719 demonstrating sufficient assets, income, financial reserves or long-term
1720 care insurance to provide for such expenses and maintain financially
1721 viable operation of the facility for a thirty-year period based on
1722 generally accepted accounting practices and actuarial principles, which
1723 demonstration (A) may include making available to prospective
1724 residents long-term care insurance policies which are substantially
1725 equivalent in value and coverage to policies precertified pursuant to
1726 section 38a-475, (B) shall include establishing eligibility criteria and
1727 screening each resident prior to admission and annually thereafter to
1728 ensure that his assets, income and insurance coverage are sufficient in
1729 combination with other sources of facility funding to cover such
1730 expenses, (C) shall include entering into contracts with residents
1731 concerning monthly or other periodic fees payable by residents for
1732 services provided, and (D) allowing residents whose expenses are not
1733 covered by insurance to pledge or transfer income, assets or proceeds
1734 from the sale of assets in amounts sufficient to cover such expenses; (4)
1735 a facility which demonstrates it will establish a contingency fund, prior
1736 to becoming operational, in an initial amount of five hundred
1737 thousand dollars which shall be increased in equal annual increments
1738 to at least one million dollars by the start of the facility's sixth year of
1739 operation and which shall be replenished within twelve months of any
1740 expenditure, provided the amount to be replenished shall not exceed

1741 two hundred fifty thousand dollars annually until one million dollars
1742 is reached, to provide for the expenses of the continuum of care to be
1743 made available to residents which may not be covered by residents'
1744 assets, income or insurance, provided the commissioner may approve
1745 the establishment of a contingency fund in a lesser amount upon the
1746 application of a facility for which a lesser amount is appropriate based
1747 on the size of the facility; and (5) a facility which is operated by
1748 management with demonstrated experience and ability in the
1749 operation of similar facilities. Notwithstanding the provisions of this
1750 subsection, a facility may be deemed a continuing care facility which
1751 guarantees life care for its residents if (A) the facility meets the criteria
1752 set forth in subdivisions (2) to (5), inclusive, of this subsection, was
1753 Medicaid certified prior to October 1, 1993, and has been deemed
1754 qualified to enter into a continuing care contract under chapter 319hh
1755 for at least two consecutive years prior to filing its certificate of need
1756 application under this section, provided (i) no additional bed
1757 approved pursuant to this section shall be Medicaid certified; (ii) no
1758 patient in such a bed shall be involuntarily transferred to another bed
1759 due to his eligibility for Medicaid and (iii) the facility shall pay the cost
1760 of care for a patient in such a bed who is Medicaid eligible and does
1761 not wish to be transferred to another bed or (B) the facility is operated
1762 exclusively by and for a religious order which is committed to the care
1763 and well-being of its members for the duration of their lives and whose
1764 members are bound thereto by the profession of permanent vows. On
1765 and after July 1, 1997, the Department of Social Services shall give
1766 priority to a request for modification of a certificate of need from a
1767 continuing care facility which guarantees life care for its residents
1768 pursuant to the provisions of this subsection.]

1769 [(c)] (b) For the purposes of this section and sections 17b-352 and
1770 17b-353, as amended by this act, construction shall be deemed to have
1771 begun if the following have occurred and the department has been so
1772 notified in writing within the thirty days prior to the date by which
1773 construction is to begin: (1) All necessary town, state and federal
1774 approvals required to begin construction have been obtained,

1775 including all zoning and wetlands approvals; (2) all necessary town
1776 and state permits required to begin construction or site work have
1777 been obtained; (3) financing approval, as defined in subsection [(d)] (c)
1778 of this section, has been obtained; and (4) construction of a structure
1779 approved in the certificate of need has begun. For the purposes of this
1780 subsection, commencement of construction of a structure shall include,
1781 at a minimum, completion of a foundation. Notwithstanding the
1782 provisions of this subsection, upon receipt of an application filed at
1783 least thirty days prior to the date by which construction is to begin, the
1784 commissioner may deem construction to have begun if: (A) An owner
1785 of a certificate of need has fully complied with the provisions of
1786 subdivisions (1), (2) and (3) of this subsection; (B) such owner submits
1787 clear and convincing evidence that he has complied with the
1788 provisions of this subsection sufficiently to demonstrate a high
1789 probability that construction shall be completed in time to obtain
1790 licensure by the Department of Public Health on or before the date
1791 required pursuant to subsection (a) of this section; (C) construction of a
1792 structure cannot begin due to unforeseeable circumstances beyond the
1793 control of the owner; and (D) at least ten per cent of the approved total
1794 capital expenditure or two hundred fifty thousand dollars, whichever
1795 is greater, has been expended.

1796 [(d)] (c) For the purposes of subsection [(c)] (b) of this section,
1797 subject to the provisions of subsection [(e)] (d) of this section, financing
1798 shall be deemed to have been obtained if the owner of the certificate of
1799 need receives a commitment letter from a lender indicating an
1800 affirmative interest in financing the project subject to reasonable and
1801 customary conditions, including a final commitment from the lender's
1802 loan committee or other entity responsible for approving loans. If a
1803 lender which has issued a commitment letter subsequently refuses to
1804 finance the project, the owner shall notify the department in writing
1805 within five business days of the receipt of the refusal. The owner shall,
1806 if so requested by the department, provide the commissioner with
1807 copies of all communications between the owner and the lender
1808 concerning the request for financing. The owner shall have one further

1809 opportunity to obtain financing which shall be demonstrated by
1810 submitting another commitment letter from a lender to the department
1811 within thirty days of the owner's receipt of the refusal from the first
1812 lender.

1813 [(e) On and after March 1, 1993, financing] (d) Financing shall be
1814 deemed to have been obtained for the purposes of this section and
1815 sections 17b-352 and 17b-353, as amended by this act, if the owner of
1816 the certificate of need has (1) received a final commitment for financing
1817 in writing from a lender or (2) provided evidence to the department
1818 that the owner has sufficient funds available to construct the project
1819 without financing.

1820 [(f) Any decision of the Office of Health Care Access issued prior to
1821 July 1, 1993, as to whether construction has begun or financing has
1822 been obtained for nursing home beds approved by the office prior to
1823 said date shall be deemed to be a decision of the Commissioner of
1824 Social Services for the purposes of this section and sections 17b-352
1825 and 17b-353.]

1826 [(g)] (e) (1) A continuing care facility, [which guarantees life care for
1827 its residents, as defined in subsection (b) of this] as described in section
1828 17b-520, (A) shall arrange for a medical assessment to be conducted by
1829 an independent physician or an access agency approved by the Office
1830 of Policy and Management and the Department of Social Services as
1831 meeting the requirements for such agency as defined by regulations
1832 adopted pursuant to subsection (e) of section 17b-342, prior to the
1833 admission of any resident to the nursing facility and shall document
1834 such assessment in the resident's medical file and (B) may transfer or
1835 discharge a resident who has intentionally transferred assets in a sum
1836 which will render the resident unable to pay the cost of nursing facility
1837 care in accordance with the contract between the resident and the
1838 facility.

1839 (2) A continuing care facility, [which guarantees life care for its
1840 residents, as defined in subsection (b) of this] as described in section

1841 17b-520, may, for the seven-year period immediately subsequent to
1842 becoming operational, accept nonresidents directly as nursing facility
1843 patients on a contractual basis provided any such contract shall
1844 include, but not be limited to, requiring the facility (A) to document
1845 that placement of the patient in such facility is medically appropriate;
1846 (B) to apply to a potential nonresident patient the financial eligibility
1847 criteria applied to a potential resident of the facility; [pursuant to said
1848 subsection (b);] and (C) to at least annually screen each nonresident
1849 patient to ensure the maintenance of assets, income and insurance
1850 sufficient to cover the cost of at least forty-two months of nursing
1851 facility care. A facility may transfer or discharge a nonresident patient
1852 upon the patient exhausting assets sufficient to pay the costs of his care
1853 or upon the facility determining the patient has intentionally
1854 transferred assets in a sum which will render the patient unable to pay
1855 the costs of a total of forty-two months of nursing facility care from the
1856 date of initial admission to the nursing facility. Any such transfer or
1857 discharge shall be conducted in accordance with section 19a-535. The
1858 commissioner may grant one or more three-year extensions of the
1859 period during which a facility may accept nonresident patients,
1860 provided the facility is in compliance with the provisions of this
1861 section.

1862 [(h) Notwithstanding the provisions of subsection (a) of this section,
1863 if an owner of an approved certificate of need for additional nursing
1864 home beds has notified the Office of Health Care Access or the
1865 Department of Social Services on or before September 30, 1993, of his
1866 intention to utilize such beds for a continuing care facility which
1867 guarantees life care for its residents in accordance with subsection (b)
1868 of this section and has filed documentation with the Department of
1869 Social Services on or before September 30, 1994, demonstrating the
1870 requirements of said subsection (b) have been met, the certificate of
1871 need shall not expire.

1872 (i) The Commissioner of Social Services may waive or modify any
1873 requirement of this section, except subdivision (1) of subsection (b)

1874 which prohibits participation in the Medicaid program, to enable an
1875 established continuing care facility registered pursuant to chapter
1876 319hh prior to September 1, 1991, to add nursing home beds provided
1877 the continuing care facility agrees to no longer admit nonresidents into
1878 any of the facility's nursing home beds except for spouses of residents
1879 of such facility and provided the addition of nursing home beds will
1880 not have an adverse impact on the facility's financial stability, as
1881 defined in subsection (b) of this section, and are located within a
1882 structure constructed and licensed prior to July 1, 1992.]

1883 [(j)] (f) The Commissioner of Social Services [shall] may adopt
1884 regulations, in accordance with chapter 54, to implement the
1885 provisions of this section. The commissioner shall implement the
1886 standards and procedures of the Office of Health Care Access division
1887 of the Department of Public Health concerning certificates of need
1888 established pursuant to section 19a-643, as appropriate for the
1889 purposes of this section, until the time final regulations are adopted in
1890 accordance with said chapter 54.

1891 Sec. 18. Subsection (c) of section 19a-654 of the general statutes is
1892 repealed and the following is substituted in lieu thereof (*Effective July*
1893 *1, 2017*):

1894 (c) An outpatient surgical facility, as defined in section 19a-493b, a
1895 short-term acute care general or children's hospital, or a facility that
1896 provides outpatient surgical services as part of the outpatient surgery
1897 department of a short-term acute care hospital shall submit to the
1898 office the data identified in subsection [(c)] (b) of section 19a-634, as
1899 amended by this act. The office shall convene a working group
1900 consisting of representatives of outpatient surgical facilities, hospitals
1901 and other individuals necessary to develop recommendations that
1902 address current obstacles to, and proposed requirements for, patient-
1903 identifiable data reporting in the outpatient setting. On or before
1904 February 1, 2012, the working group shall report, in accordance with
1905 the provisions of section 11-4a, on its findings and recommendations to
1906 the joint standing committees of the General Assembly having

1907 cognizance of matters relating to public health and insurance and real
1908 estate. Additional reporting of outpatient data as the office deems
1909 necessary shall begin not later than July 1, 2015. On or before July 1,
1910 2012, and annually thereafter, the Connecticut Association of
1911 Ambulatory Surgery Centers shall provide a progress report to the
1912 Department of Public Health, until such time as all ambulatory surgery
1913 centers are in full compliance with the implementation of systems that
1914 allow for the reporting of outpatient data as required by the
1915 commissioner. Until such additional reporting requirements take effect
1916 on July 1, 2015, the department may work with the Connecticut
1917 Association of Ambulatory Surgery Centers and the Connecticut
1918 Hospital Association on specific data reporting initiatives provided
1919 that no penalties shall be assessed under this chapter or any other
1920 provision of law with respect to the failure to submit such data.

1921 Sec. 19. Subsection (b) of section 19a-486b of the general statutes is
1922 repealed and the following is substituted in lieu thereof (*Effective July*
1923 *1, 2017*):

1924 (b) The commissioner and the Attorney General may place any
1925 conditions on the approval of an application that relate to the purposes
1926 of sections 19a-486a to 19a-486h, inclusive. In placing any such
1927 conditions the commissioner shall follow the guidelines and criteria
1928 described in [subdivision (4) of] subsection [(d)] (e) of section 19a-639,
1929 as amended by this act. Any such conditions may be in addition to any
1930 conditions placed by the commissioner pursuant to [subdivision (4) of]
1931 subsection [(d)] (e) of section 19a-639, as amended by this act.

1932 Sec. 20. Section 17b-59f of the general statutes is repealed and the
1933 following is substituted in lieu thereof (*Effective July 1, 2017*):

1934 (a) There shall be a State Health Information Technology Advisory
1935 Council to advise the Health Information Technology Officer,
1936 designated in accordance with section 19a-755, in developing priorities
1937 and policy recommendations for advancing the state's health
1938 information technology and health information exchange efforts and

1939 goals and to advise the Health Information Technology Officer in the
1940 development and implementation of the state-wide health information
1941 technology plan and standards and the State-wide Health Information
1942 Exchange, established pursuant to section 17b-59d. The advisory
1943 council shall also advise the Health Information Technology Officer
1944 regarding the development of appropriate governance, oversight and
1945 accountability measures to ensure success in achieving the state's
1946 health information technology and exchange goals.

1947 (b) The council shall consist of the following members:

1948 (1) The Health Information Technology Officer, appointed in
1949 accordance with section 19a-755, or the Health Information
1950 Technology Officer's designee;

1951 (2) The Commissioners of Social Services, Mental Health and
1952 Addiction Services, Children and Families, Correction, Public Health
1953 and Developmental Services, or the commissioners' designees;

1954 (3) The Chief Information Officer of the state, or the Chief
1955 Information Officer's designee;

1956 (4) The chief executive officer of the Connecticut Health Insurance
1957 Exchange, or the chief executive officer's designee;

1958 (5) The director of the state innovation model initiative program
1959 management office, or the director's designee;

1960 (6) The chief information officer of The University of Connecticut
1961 Health Center, or said chief information officer's designee;

1962 (7) The Healthcare Advocate, or the Healthcare Advocate's
1963 designee;

1964 (8) The Comptroller, or the Comptroller's designee;

1965 [(8)] (9) Five members appointed by the Governor, one each of
1966 whom shall be (A) a representative of a health system that includes

1967 more than one hospital, (B) a representative of the health insurance
1968 industry, (C) an expert in health information technology, (D) a health
1969 care consumer or consumer advocate, and (E) a current or former
1970 employee or trustee of a plan established pursuant to subdivision (5) of
1971 subsection (c) of 29 USC 186;

1972 [(9)] (10) Three members appointed by the president pro tempore of
1973 the Senate, one each who shall be (A) a representative of a federally
1974 qualified health center, (B) a provider of behavioral health services,
1975 and (C) a representative of the Connecticut State Medical Society;

1976 [(10)] (11) Three members appointed by the speaker of the House of
1977 Representatives, one each who shall be (A) a technology expert who
1978 represents a hospital system, as defined in section 19a-486i, (B) a
1979 provider of home health care services, and (C) a health care consumer
1980 or a health care consumer advocate;

1981 [(11)] (12) One member appointed by the majority leader of the
1982 Senate, who shall be a representative of an independent community
1983 hospital;

1984 [(12)] (13) One member appointed by the majority leader of the
1985 House of Representatives, who shall be a physician who provides
1986 services in a multispecialty group and who is not employed by a
1987 hospital;

1988 [(13)] (14) One member appointed by the minority leader of the
1989 Senate, who shall be a primary care physician who provides services in
1990 a small independent practice;

1991 [(14)] (15) One member appointed by the minority leader of the
1992 House of Representatives, who shall be an expert in health care
1993 analytics and quality analysis;

1994 [(15)] (16) The president pro tempore of the Senate, or the
1995 president's designee;

1996 [(16)] (17) The speaker of the House of Representatives, or the
1997 speaker's designee;

1998 [(17)] (18) The minority leader of the Senate, or the minority leader's
1999 designee; and

2000 [(18)] (19) The minority leader of the House of Representatives, or
2001 the minority leader's designee.

2002 (c) Any member appointed or designated under subdivisions [(9)]
2003 (10) to [(18)] (19), inclusive, of subsection (b) of this section may be a
2004 member of the General Assembly.

2005 (d) The Health Information Technology Officer, appointed in
2006 accordance with section 19a-755, shall serve as a chairperson of the
2007 council. The council shall elect a second chairperson from among its
2008 members, who shall not be a state official. The terms of the members
2009 shall be coterminous with the terms of the appointing authority for
2010 each member and subject to the provisions of section 4-1a. If any
2011 vacancy occurs on the council, the appointing authority having the
2012 power to make the appointment under the provisions of this section
2013 and shall appoint a person in accordance with the provisions of this
2014 section. A majority of the members of the council shall constitute a
2015 quorum. Members of the council shall serve without compensation,
2016 but shall be reimbursed for all reasonable expenses incurred in the
2017 performance of their duties.

2018 (e) Prior to submitting any application, proposal, planning
2019 document or other request seeking federal grants, matching funds or
2020 other federal support for health information technology or health
2021 information exchange, the Health Information Technology Officer or
2022 the Commissioner of Social Services shall present such application,
2023 proposal, document or other request to the council for review and
2024 comment.

2025 Sec. 21. Sections 17b-354b and 17b-354c of the general statutes are
2026 repealed. (*Effective July 1, 2017*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2018	New section
Sec. 2	July 1, 2017	19a-630
Sec. 3	July 1, 2017	19a-634
Sec. 4	July 1, 2017	19a-637
Sec. 5	July 1, 2017	19a-638
Sec. 6	July 1, 2017	19a-639
Sec. 7	July 1, 2017	19a-639a
Sec. 8	July 1, 2017	19a-639b(e)
Sec. 9	July 1, 2017	19a-639c
Sec. 10	July 1, 2017	19a-639e
Sec. 11	July 1, 2017	19a-639f
Sec. 12	July 1, 2017	19a-653
Sec. 13	July 1, 2017	19a-486d(a)
Sec. 14	July 1, 2017	19a-486i
Sec. 15	July 1, 2017	17b-352(a) to (c)
Sec. 16	July 1, 2017	17b-353
Sec. 17	July 1, 2017	17b-354
Sec. 18	July 1, 2017	19a-654(c)
Sec. 19	July 1, 2017	19a-486b(b)
Sec. 20	July 1, 2017	17b-59f
Sec. 21	July 1, 2017	Repealer section

Statement of Legislative Commissioners:

In Section 7(e), the phrase "Except as provided in this subsection, the" was bracketed and "The" was added for accuracy.

PH *Joint Favorable Subst.*